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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

Unaccompanied Refugee Children

Services and Unmarried Mothers

Perceptions of Behavior Change

A Study of Health Attitudes

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

children
®

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◀

THE POWER OF LOVE as a nutrient in the growth of a child—with its special potency in helping the child who is mentally retarded—has stimulated some communities to organize programs in which volunteers such as this teenage girl learn to blend compassion and understanding in their care of mentally retarded children. Programs such as these inspired the President's Panel on Mental Retardation to include in its recommendations the proposal that volunteer services for retarded children be part of the operations of a Domestic Peace Corps. Highlights from the panel's report are reviewed on pages 33–36 of this issue.

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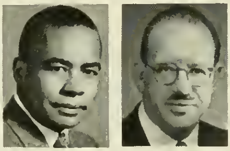
◀ *the authors*

In addition to his work at the Mount Sinai Hospital in New York, DR. RASHBAUM teaches at Albert Einstein Medical College and serves as assistant visiting physician at Jacobi Hospital and adjunct physician at Beth Israel Hospital. HELEN BEHR and JANICE PANETH are experienced in family casework and medical social work; both are graduates of the New York School of Social Work. Also experienced in family casework as well as in community organization, MARTIN GREENBERG is a graduate of the Indiana School of Social Work. He is director of field service for the Council of Jewish Federations and Welfare Funds.

Each summer, psychologist ELTON MCNEIL directs the Fresh Air Camp for aggressive children described in his article, where students in clinical psychology, psychiatric nursing, psychiatric group work, and special education receive clinical training. He is currently engaged in a longitudinal study of aggression in schools and a study of the effectiveness of providing mental health consultation in the schools.



After a medical school survey in Ghana in 1961, DR. CORNELY has resumed his duties at Howard University. These include, in addition to his public health responsibilities, serving as chief of the division of physical medicine and rehabilitation of the university and Freedmens Hospital. STANLEY BIGMAN now directs social studies in occupational health for the U.S. Public Health Service. He has taught sociology and participated in research at Rutgers, Columbia, and American Universities, and Gallaudet College.

LEON YARROW, research psychologist, has focused his interests on the effects of early experiences on personality development. He is now directing a longitudinal study of adopted children. One-time research assistant at the Child Welfare Research Station, University of Iowa, where he secured his doctorate, he was on the staff of the Children's Bureau from 1951 to 1954. Prior to that he participated in studies at the University of Colorado and at Cornell.

Before coming to the Children's Bureau in 1956, RUDOLF HORMUTH was assistant to the executive director of the Association for the Help of Retarded Children, a statewide organization in New York. Previously, as social work supervisor in the Jewish Hospital of Brooklyn, he helped set up one of the country's first clinics for the retarded.

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Observations of a peripatetic reporter on the care of . . .

CUBAN CHILDREN AWAY FROM HOME

KATHRYN CLOSE

"CHILDREN ARE ALIKE everywhere. The only differences are in the rules made by adults."

This remark was made recently by a 15-year-old Cuban girl now living with an American family in Albuquerque, N. Mex. It aptly describes the source of some of the joys and difficulties being experienced by the hundreds of persons in communities throughout this country who as foster parents or members of the staffs of children's agencies, institutions, or boarding schools are participating in the Federal Government's program for the care of "unaccompanied" Cuban children—young people usually between the ages of 6 and 19 who in the last 2 years have come to this country from Cuba without their parents and with no relative here to care for them.

Sent out of Cuba by their parents to escape Communist indoctrination, these young refugees—nearly 8,000 in all—have for the most part demonstrated the remarkable ability of young personalities well-grounded in close family ties to withstand extended emotional strain. They have, however, faced those who have been involved in their care with a renewed realization of the importance of three social work maxims: know the culture with which you are dealing; understand the basic needs of children in every culture; and appreciate the individuality in every child.

Coming from all classes of society, the children include the scions of sugar barons, merchants, doctors, lawyers, engineers, clerks, laborers, peasants, and fishermen; but the majority are the sons and daughters of once "comfortably off" middle class families. Most of them are in their early teens, and nearly two-thirds are boys. They have delighted their caretakers with their politeness, irritated them with their noisy chatter, enraged them with their untidiness, impressed them with their respect for their parents' wishes, and won them with their charm.

With a few exceptions where placements have been made by public agencies, the care and supervision of these young emigrés are provided by local voluntary child-care agencies scattered in 93 communities from Miami, Fla., to Yakima, Wash., and licensed or approved by their State welfare departments. On October 31, 1962, these agencies had 4,010 Cuban children under their supervision, 1,453 in foster family homes, and 2,557 in local institutions for dependent and neglected children, small group homes, or private boarding schools. In addition, the agencies had returned some 4,000 other Cuban children formerly under their care to parents or other close relatives who had followed them to this country. For each child under care, the agencies receive a Federal payment on a per diem basis.

The Beginning

The provisions for unaccompanied children are part of the most comprehensive program yet devised in this country to meet a wave of incoming refugees and the first to involve the distribution of Federal financial assistance for maintenance outside of a refugee center. The program's base is in Miami, the chief port of entry, a city whose plight was one of the precipitating factors in the initiation of the Federal aid.

Soon after Castro's assumption of power in Cuba the population of Miami began to swell with the daily influx of hundreds of Cubans, arriving as "visitors" or "students" but remaining as refugees. While some of the earliest refugees managed to bring some resources with them, as time passed controls in Cuba tightened and soon the emigrés could bring hardly more than the clothes they had on. Still they came, and it gradually became apparent that the community of Miami—an area of depressed employment—could not alone meet their needs.

Accordingly the Federal Government stepped in to help—first in November 1960, when President Eisenhower allocated $1 million out of the contingency fund of the mutual security program for the purpose. This was spent for the establishment and maintenance of a refugee center in Miami as the hub of resettlement efforts being made by four long-experienced, voluntary refugee relief agencies—the National Catholic Welfare Conference, the International Rescue Committee, the Church World Service, and the United HIAS Service; for defraying transportation costs; and for the unpublicized beginnings of foster care for unaccompanied Cuban children. Later, in February 1961, President Kennedy ordered a program to be developed by the Department of Health, Education, and Welfare for meeting the minimum needs of the refugees for daily subsistence, resettlement, employment, education, and health, and for the care and protection of unaccompanied children.

Additional monies from the President's contingency fund supported the program until the 87th Congress, under authorization of a new Migration and Refugee Assistance Act passed in June 1962, appropriated $70,110,000 to carry on the program for the 1963 fiscal year. Of this, $13,800,000 is for the unaccompanied children's program.

The administration of the subsistence and foster-care phases of the refugee program is carried out by the Florida State Department of Public Welfare under contract with the U.S. Department of Health, Education, and Welfare's Bureau of Family Services and the Children's Bureau. The Florida department in turn has subcontracts with HIAS and three local voluntary children's agencies—the Catholic Welfare Bureau of the Diocese of Miami, the Children's Service Bureau, and the Jewish Family and Children's Service—for arranging for the placement of children.

The Catholic Welfare Bureau and the Children's Service Bureau, responsible respectively for Catholic and Protestant Cuban children, not only receive and place children in Miami but also find child-caring agencies elsewhere willing and able to take Cuban children into care. HIAS arranges for the out-of-town placements of Jewish Cuban children, and the Jewish Family and Children's Service provides for those who need placement in Miami.

The Placement Agencies

Much of the early stimulus for the program for unaccompanied children came from the then Reverend—now Monsignor—Bryan O. Walsh, director of the Catholic Welfare Bureau of Miami, which, because about 95 percent of the Cuban children are Catholic, has carried the burden of the placements. In the fall of 1960 after his agency had just suffered a 30-percent budget cut, Father Walsh met Pedro, a 15-year-old Cuban boy who for the whole month he had been in Miami had been spending each day with a different Cuban refugee family, none of whom could keep him. About the same time he began to hear stories of Cuban children in Miami who had been placed in the care of emigrating strangers at the Havana airport when their parents had been refused permission to leave. Sensing an oncoming flood of child-care problems with the breakdown of such haphazard parental placements, he called a meeting of the Family and Children's Division of the Miami Welfare Planning Council. As a result, the three Miami child-placing agencies offered their services in a suggested Government sponsored foster-care program for unaccompanied Cuban children.

They heard nothing until Christmas Eve 1960, when Father Walsh received a request from the U.S. State Department to make arrangements for the care of 200 Cuban children who were about to leave Havana. On December 26, the first official "unaccompanied children" arrived—10 teenage boys. Fortunately, the absence for the holidays of the student body of a local boarding school provided them and the 15 other boys who arrived in a few days with an immediate place to stay.

This was the beginning of an increasing influx of unaccompanied Cuban children to Miami—which by the summer of 1961 was running about 200 children a week—and of an ever-accelerating tempo in Father Walsh's efforts to find suitable living quarters and supervision for them—often on a moment's notice. He solved his first problem, presented by the students' return from their holidays, by moving into a donated, unfurnished house with 10 Cuban boys and some army cots—taking the boys for meals to the academy across the street. (The other 15 Cuban children in the Christmas package of 1960 needed only to be dispatched to relatives in this country.)

Since then this first home for Cuban boys has expanded to a two-house home for 40 Cuban boys run by Cuban Jesuits. In addition, the Catholic Welfare Bureau has converted a summer retreat for priests, called Camp Matacumbe, to a receiving home and school, which now houses 350 teenage Cuban boys; borrowed a building at Kendall, the institutional grounds of the Dade County Welfare Department, for use as a receiving home, now housing 205 boys; converted 3 rows of garden apartments in Florida City to a receiving home and school for girls and younger boys, which now holds about 465 boys and girls; and converted a two-building group of apartments in Miami to a cottage-type institution, called St. Raphael's Home for Boys, now housing 74 boys.

In addition to these facilities the Catholic Welfare Bureau has from the beginning used foster-family placements, especially among Cuban couples, for both emergency and more permanent care of Cuban children; and with the help of the National Conference of Catholic Charities has formed a pool of 95 Catholic child-caring agencies and institutions in 36 States which have been willing to take Cuban children into care. Its Cuban refugee unit has a staff of 406 persons. By October 31, 1962, the agency had handled 6,837 children in the Federal unaccompanied children's program. Of these, 3,523 children were still in foster care.

Although faced with a much smaller group of Cuban children—375 in all by October 31, 1962—the Children's Service Bureau was at first also hard pressed in making arrangements for care. With no countrywide network of child-caring agencies with which to deal and with children (or their parents) insisting that denominational lines not be crossed in placement, the agency had to struggle on the one hand with placement offers from church groups lacking qualified child-placing staff, and, on the other, with difficulties in locating licensed or approved child-caring agencies ready to study and supervise homes offered for Cuban children. Last spring, however, after the Child Welfare League of America held a meeting to discuss the program, offers of participation from denominationally sponsored or nonsectarian child-caring agencies stepped up. By October 31, 1962, the agency had been able to send some 190 children to other communities for care, 142 of whom were still in care. The agency still had 77 children in care in Miami—10 in a small Methodist home, the rest in foster homes.

The United HIAS Service, which in its long experience with refugee children since the early days of Hitler has built up close relationships with Jewish child-caring agencies throughout the country, had by October 31, 1962, sent 117 children out of Miami for foster care under the program, nearly all of whom were placed with foster families. At the end of last October, 54 of the children were still in foster care.

The Jewish Family and Children's Service has placed only a handful of Cuban children in regular foster care in Miami, but it has provided emergency care for nearly all the new arrivals eventually placed elsewhere by HIAS.

All of these agencies have also helped many unaccompanied children not in the foster-care program to reach the homes of relatives who have promised to care for them.

The Child Welfare Division of the Florida State Department of Public Welfare, while concerned chiefly with the administrative and fiscal phases of the unaccompanied children's program, also carries a direct caseload of some 90 children in foster family care and in small group homes in Miami. While these include some "boat boys"—teenagers who came from Cuba on their own initiative in fishermen's boats or other small craft—they are for the most

A group of Cuban boys with Msgr. Bryan O. Walsh, director of the Catholic Welfare Bureau, at St. Raphael's Home, one of the facilities for the care of Cuban children in Miami.

part children who had been sent by their parents to the care of relatives, friends, or comparative strangers who were unable to give them a good home. They include, for example, an emotionally upset 10-year-old girl left in a boarding school by a man who disappeared; a 15-year-old boy sent to a hostile grandmother; a 12-year-old boy sent to an unrelated widow who feared he might have a bad effect on her teenage daughters.

Because of such evidences of unfortunate situations for children resulting from hasty parental plans, the Florida child welfare division is making home studies of all the "guardian cases" in the Cuban refugee program's financial assistance load in Miami—cases in which Cuban families receive a monthly payment ($28–$36) for an unrelated child placed in their care by his parents.

The efforts of the receiving agencies to get the children out of the crowded conditions in Miami were for a long while somewhat hampered by the reluctance of many of the youngsters to leave an area where they felt close to home and had many friends. Even after the unsuccessful Bay of Pigs invasion many of the young people seemed so sure that they were in this country for only a short stay that they not only saw no point in leaving Miami but took little interest in learning English. This attitude—clung to by some of the children even after being sent to foster homes where nobody spoke Spanish—has now generally given way to a wish to learn English as rapidly as possible "so that I will be able to help my parents when they get here."

While most of the young people learn English quickly when in school with American children, nearly all the Cuban children in Miami have been somewhat handicapped in this by the fact that they are with Cubans most of the time—whether with their own parents or in foster family homes, where there are often several other Cuban children and even Spanish-speaking foster parents, or in the large group homes, where all the children and most of the staff speak Spanish. Even in the public schools the children are apt to speak Spanish except while reciting since some public schools in Miami have enrollments which are 60 to 80 percent Cuban.

Refugees With a Difference

Many of the agencies across the country which have taken Cuban children into care are participating in an unaccompanied children's program for the first time. Others are old hands at transplanting uprooted children from other countries. But even those with considerable experience of this nature have found themselves in for many new experiences.

On the plus side has been the fact that the children, on the whole, have seemed more emotionally stable than many of their forerunners. They have not been through blitzkrieg like the British children brought here in 1940, or seen the horrors of a concentration camp, as had so many of the displaced children of post-War Europe, or fought against tanks with hand grenades as had the Hungarian teenage refugees of 1957. While the fathers or brothers of some of the Cuban children had been killed or imprisoned as a result of the revolution, the great majority of the children apparently lived well-sheltered lives up to the point of actual separation from their parents. Most of them apparently were well prepared for "being sent to school in the United States"—not a new practice among well-to-do Cuban families. Moreover, they have continued to be in constant touch with their parents by phone and mail and have expected to see them shortly.

The first thing nearly every unaccompanied child has done on his arrival in Miami is to inquire about getting his parents a visa waiver—a visa substitute issued by the U.S. State Department after the January 1961 removal of all United States consular services from Cuba. Until the recent Cuban crisis, visa waivers, signed by sponsoring agencies, could be mailed to Cuba for "students" 6 to 18, and visa waivers for adults could be mailed to them after being signed by a first degree relative in this country. Thus, families desiring to leave Cuba could send their children out as "students" and come themselves on visa waivers initiated by their children. Waiting periods between children's and parents' arrivals have varied from 3 months to 2 years—much of the delays having to do with the parents' difficulties in getting dollars to pay for their transportation and in getting permission from the Cuban police to leave the country.

Because refugees to the United States have had to turn over all their possessions to the Castro government before leaving, a few parents have apparently preferred to stay in Cuba in the hope of riding out the storm. Others have been unable to leave, either because of loyalty to their own aged parents who cannot be moved, the refusal of the Cuban government to release them, imprisonment, or other difficulties.

The provision of foster care for Cuban children has from the beginning been regarded by all concerned as a temporary measure to last only until parents and children can be reunited. The absent parents remain the children's guardians, and in many instances continue to supervise their behavior by phone and mail. The older children tend to consult their parents by telephone before making any major decisions or accepting any plans made for them by agency or school—reversing the charges so that the bill can be paid with pesos in Cuba.

This deference to parents has been the cause of both joy and consternation to the agencies caring for Cuban children. While struck with the children's unquestioning obedience to their parents, they have on occasion found some of the parents' instructions to their children rather trying—as when a once-pampered daughter was told she did not need to help her foster mother with the dishes, or when a girl with a severe toothache refused to go to the dentist because her mother told her the cavity in her tooth would close if she took calcium pills. One agency had to call on a priest to write a long letter about children's needs to a mother who kept instructing her little 10-year-old boy to "pray for Cuba instead of playing."

The closeness of Cuban children to their families, however, is regarded by many social workers in the program as the chief asset in the emotional strength which has enabled the great majority of children to take such a precarious separation from their parents with apparent calmness. While some of them have been found crying at night by their foster parents, relatively few have been reported as showing symptoms of severe emotional disturbance—and these have usually been children who came from homes where the customary Cuban closeness between parents and children did not prevail.

"We expected all kinds of problems and they just didn't happen," says a child welfare worker who has supervised the placement of 91 Cuban children. "These children just aren't like the deprived children we see in our regular foster-care program."

Cultural Difficulties

There have, of course, been some minor difficulties due to cultural differences. Diet has been one of the most common, arising from the Cuban child's apparent dislike of everything except meat, black beans, and sugar. Being expected to eat vegetables has been the cause of many a complaint to parents. One mother wrote anxiously to an institution for an explanation of her daughter's charge: "Here they feed us only spinaches." On the other hand, another mother, reunited with her son in Florida, wrote to his former foster mother, who had weaned him from "stomach pills" to vegetables, for her "recipe for a balanced diet."

These young Cubans are waiting at the Miami airport with their agency escort (right) for the plane which will take them to another community in this country for foster care.

The greatest source of trouble has come from the fact that many of the youngsters had been waited on by servants all their lives. Some children have been genuinely shocked when asked to take out the garbage or even to pick up their clothes, and in a number of instances a battle of wills has ensued. Some foster parents have even given up and asked for the removal of teenagers who refused to do the kind of chores their own children were accustomed to doing. Often when the Cuban child has found the same things expected of him in his second foster home he has finally realized that asking young people to help around the house is an American custom and not a form of deliberate exploitation.

At the same time, caseworkers have spent considerable time in helping foster parents and houseparents to see that the Cuban child's failure to be helpful does not always derive from unwillingness, but often from simply not knowing how to do what is expected of him. One teenage girl, for example, had never even seen a bed being made.

As time has passed many of the Cuban children have learned to do many things. A group of boarding school girls, for example, described by the superintendent as "rather trying" when they first came to the school in the summer of 1961, last spring gave an "appreciation" party for the staff, doing all the preparation and cleaning up themselves. And a 12-

year-old boy has written his parents in Cuba that he will help them learn to keep house when they come to the United States.

The concept of a foster family is unknown in Cuba, and therefore some of the Cuban children (and their parents) have had difficulty in understanding the role of the foster parents. Expecting placement in a boarding school, some teenagers have at first resisted the idea of living with an American family, and then apparently accepted it only as a kind of boarding arrangement. Thus while accustomed to obey adults in authority, some of them—especially the boys—have been slow in recognizing the authority of the foster parents. Difficulties in communication because of language differences have sometimes aggravated the problem. However, the younger children seem to settle quickly into their foster parents' home after the first frightening days of strangeness.

The difficulties are probably fewer than the satisfactions. Many foster parents have become extremely fond of the young Cubans in their care. They write to the children's parents in Cuba frequently, and in a number of instances have been instrumental in helping them find jobs after they arrive in the United States. Some foster parents have even taken the children's parents into their homes until they have become established.

School principals report that the Cuban children's behavior is on the whole excellent although they "talk a lot in class" and stay away "on the slightest pretext"—a hard rain, their Saint's day, or, in Miami, a "feeling" that their parents might be arriving. One foster mother of two teenage girls has come to the conclusion from the girls' description of the customs in the private school they used to attend that in Cuba "the students ran the schools." This conclusion would undoubtedly be concurred in by the high school principal in Albuquerque who was told by a group of polite, registering Cuban boys that they would "like to reserve the right to strike."

As with all programs involving aliens, the Cuban program has met with resistance in some communities. There are those where resentment has been expressed over "doing more for the Cuban children than we are doing for our own;" and some where school boards have raised objections to taking "these nonresidents" into the public schools.

However, in spite of some initial difficulties with their foster parents and a few among themselves (as in the group home where the boys have divided into two rival factions based on loyalties to their Miami "alma maters," Camp Kendall and Camp Matacumbe), the Cuban youngsters have won friends wherever they have gone. It has not taken people long to discover that they are well-behaved in public, good-natured, law-abiding, and often very bright.

Foster Care Arrangements

The agencies have found a variety of ways to provide care for the Cuban children. Those which have taken responsibility for large numbers of children—and some have accepted from 100 to 300 children in all—have hired additional caseworkers and set up special units for the program.

Most of the agencies using group care have relied on existing facilities, but a few have opened up special homes for teenage boys using refugee couples as houseparents or, in some instances, members of religious orders who have fled from Cuba. For example, in Montana, 40 boys are living in what was once the governor's mansion, supervised by 2 refugee couples. And in Portland, Oreg., an agency has rented 6 houses in a residential area, each house serving as a home for 5 or 6 Cuban teenagers and a Cuban refugee couple employed as houseparents.

Some agencies have hesitated to place Cuban children in institutions for dependent and neglected children because of the emotional difficulties of so many of the institutions' regular charges; and in fact Cuban children have protested vehemently against being put into "an orphans' home." In Denver, Colo., a group of Cuban teenage girls who were placed in an institution with Mexican-Americans, where it was thought they would feel at home because the other girls spoke Spanish, for a long time would have nothing to do with the other girls. By now, however, some fast friendships have been formed across the nationality lines.

On the other hand, in a home for younger boys near New Orleans, La., operated by a group of warmth-radiating nuns, only two of nine Cuban boys seemed to have any difficulty in adjusting. One, a 6-year-old, unfortunately arrived with a skin infection which required him to be placed in isolation during his first week in the institution; but his constant crying ceased when he was allowed to be with the older boys. The other, aged 9, eventually changed his rebellious behavior after being "taken in hand" by the other Cuban boys.

The agency responsible for these boys has placed Cuban children in a total of four institutions, and has provided them as caseworker a Cuban lawyer—working under the supervision of a professional social worker—who through his frequent visits has become a "father figure" for many of the children.

Some agencies which use group care make special efforts to find week-end and holiday foster parents to give the Cuban youngsters a touch of home life. In Joliet, Ill., for example, an agency which is supervising 63 Cuban girls in 2 private boarding schools has succeeded in getting every Cuban girl invited to somebody's home at some time. However, when the agency was ready to make a special drive to get them all invitations for the Christmas holidays, they refused to leave each other. "We are a family," the girls explained, "and we want to spend our holidays at home."

Many agencies through their experience in this program have found new sources of foster-family homes, a single notice in a church bulletin often being sufficient to bring in more applications than the agency has children. As usually happens, most of the applicants have asked for little children, although most of the children needing placement are in their teens. Some applicants, however, have asked for a teenage boy or girl as a "companion" for their own son or daughter, and others have preferred a teenage child to none. In some instances, agencies have been able to interest applicants for whom they had no Cuban child in taking another child needing care away from home.

Some agencies have been unwilling to participate in the program because foster-care resources in their community are insufficient for the needs of all the dependent and neglected children in the area. However, other agencies have found for the Cubans foster parents who, the agency workers say, would never have applied to them for other children. In St. Petersburg, Fla., for example, some extremely wealthy families have taken Cuban children into their homes as have some families in more moderate circumstances. The main difficulty there seems to be that the children get together frequently by telephone to compare notes as to who has what, with some resultant jealousy.

Since Cuban children will almost invariably accept authority from a respected Cuban adult, agencies have sometimes asked a Cuban man or woman in the refugee community to talk to a child who is giving trouble to his American foster parents—a method that has often proved effective.

Cuban foster parents, in use in Miami, have had the advantage of understanding their charges' Cuban ways. They have also found the appeal "we are all in this together" a quick way of overcoming resistance to chores.

Other Spanish-speaking foster parents have been found in sections of the country where many people speak Spanish, such as the Southwest. However, agencies report that non-Spanish speaking foster parents who are warm and accepting can make the children feel just as much at home, except perhaps in the first few days of care. "We felt so sorry for them and so helpless when they first came," said one such foster mother recently of a Cuban sister and brother she has in her home. "But our own children found language no barrier to a welcome and pretty soon we were all having a hilarious time communicating with expressive noises and gestures."

Agency executives say they have learned many things from their participation in the Cuban program. For example, a few have found it possible to place Negro-Cuban and Chinese-Cuban children in white American families. Others have been impressed with the efficacy of the small group homes set up for the care of Cuban teenage boys and are planning to adopt this pattern of care for teenage boys of their own communities who need care away from home. One agency has been spurred by its experience in the Cuban program to build up a program of foster-family care for the dependent and neglected children it has always placed in an institution.

Standards and Cost

The agencies caring for Cuban children must be approved or licensed by their State welfare departments, must comply with their States' laws for licensing foster homes, and must make social casework services available to the child. The Florida State Department of Public Welfare checks with the State welfare departments on the qualifications of the agencies for receiving children.

For the care they provide the agencies receive a payment of $5 a day for each child in a foster family and $6 a day for each child in group care. An additional 50 cents daily per child goes to the Miami receiving agencies which keep reports on the status of the child and handle all the direct transactions with the agencies. Transportation costs in this country are borne by the Federal Government.

The per diem payments are expected to cover the costs of the child's board and care, clothing, medical care (except for unusual expenses), school supplies, incidentals, casework service, and the agency's administrative expenses. Providing all this under the current rates has proved to be impossible in some high cost areas of the country. For example, in New York City, where the cost of living and hence of board, salaries, and administrative expenses are extremely high, voluntary agencies maintain that the $7.50 a day they receive from the city for each child under foster-family care in their regular programs and $13.50 for group care still leave them with deficits. Even in some lower cost areas, agencies have found themselves hard put to care for Cuban children without dipping into their own resources.

Numbers under care seem to make a difference, for, as one agency executive has observed, "you have to have at least 30 children in care in order to be able to afford an additional staff member and thus not add to the caseloads of your regular staff." The rapid turnover in the Cuban caseloads, as children have been reunited with their parents and as others have come in, has also kept expenses high since all of the incoming children have had to be almost completely outfitted with clothing and many have needed an enormous amount of dental work.

Some agencies report that they are coming out about even in meeting costs through the Federal reimbursement. However, they anticipate some future nonreimbursable expenses, such as the cost of continuing to care until the end of the school term for teenagers who while still in school become 19—the cut-off age for eligibility in the program. A few agencies may find at the termination of the program that they have strengthened their abilities to serve children in their local communities; for example, one agency looks forward to eventually converting a house, bought as a group home for teenage Cubans, to a much-needed maternity home.

The effort to set a fair per diem rate in this program has highlighted the need of most child-caring agencies for better cost-analysis procedures. As a result, the Children's Bureau has been conducting workshops among interested public and voluntary agencies in the potentialities of a cost-analysis system, developed by Martin Wolins[1] on the basis of cost studies previously made by Dr. Wolins and Edward E. Schwartz for the Children's Bureau.[2] In January of this year the Catholic Welfare Bureau is introducing this system of cost analysis into its institutions in Miami.

Continuing Needs

In spite of the number of communities where agencies have accepted Cuban children, the need to relieve the overcrowded Miami resources remains. One-third of the 4,000 unaccompanied Cuban refugee children who have not been reunited with their parents or other relatives are still in care in Miami. Most of them are teenagers, especially boys, who are hardest to place in foster care. Others are the young brothers and sisters of some of these teenagers.

Plans to relieve the overcrowding at Camp Matacumbe and to close the facility at Kendall, needed for other purposes by the Dade County Public Welfare Department, have run into a snag because of the recent Cuban crisis. Last October arrangements being made for use of part of the Marine base at nearby Opa-locka for a reception center and a school for teenage boys had to be suddenly abandoned, at least temporarily, because of military requirements. The younger teenage boys were therefore sent to the home at Florida City where overcrowding had been relieved by the addition of a third block of apartments. But Matacumbe, where dormitories contain closely lined-up rows of 3-tiered bunks, still has to use part of its new gymnasium and recreation hall for sleeping quarters.

How "temporary" this temporary care will be for most of the children remains a question which is only a corollary to the many crucial questions involved in the Cuban crisis. At this writing (mid-November) no one knows when or whether the parents of these children, or any more unaccompanied children, will be arriving in this country other than the few daring souls who find their way to the Florida coast by boat.

In the meantime, letters sent by Cuban children to President and Mrs. Kennedy asking to be put in a boarding school or with an American family indicate that the once strong resistance of children to leaving Miami is breaking down. One confident teenager's argument in asking the President's help in being placed where he could have "a little family atmosphere," improve his English, study hard, and "learn the American customs" might well be used in behalf of many of the Cuban children now in Florida camps. Wrote he:

"I assure you that any North American family would be proud to have me with them."

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[1] Wolins, Martin: A manual for cost analysis in institutions for children, parts I and II. Child Welfare League of America, New York. 1962.

[2] Schwartz, Edward E.; Wolins, Martin: Cost analysis in child welfare services. U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 366. 1958.

A hospital social service department reports on a study of the . . .

USE OF SOCIAL SERVICES BY UNMARRIED MOTHERS

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THE PROBLEMS inherent in extramarital pregnancies have been of concern to social and health agencies for a very long time. In our society, to become pregnant out of wedlock is considered an act of social irresponsibility. When an out-of-wedlock pregnancy is called to the attention of our social agencies, they are expected to protect the well-being of the mother and her child and thus minimize the chances of further social breakdown to which unmarried mothers and their offspring are particularly vulnerable. Social agencies are also expected to help the unmarried mother and putative father act in a more responsible way and to help curtail, if not eliminate entirely, the repetition of out-of-wedlock pregnancies.

Recent increases in the incidence of out-of-wedlock births point up the need for all social agencies confronted with such problems to examine their effectiveness in achieving these objectives. For the country as a whole the rate of births out of wedlock increased from 3.6 percent of all live births in 1947[1] to 5.2 percent (more than 220,000) of all live births in 1959.[2] In New York City, the rate rose from 3 percent in 1946 to 8 percent in 1959.[3]

Since hospital social service departments have a unique opportunity to become acquainted with most of the unmarried mothers who receive hospital care, their medical social workers would seem to have a special responsibility to study the problem of how effective services can be provided to this group of patients.

In New York City, the Mount Sinai Hospital through its departments of obstetrics-gynecology and social service undertook to study its patients who had become pregnant out of wedlock to determine their social characteristics, medical conditions, use of hospital services, and use of the community's social agencies. The study, which was initiated in mid-1958, covered all women cared for in the obstetrics pavilion and known to the social service department during the calendar years 1956 and 1957 who were registered as unmarried. The social service department's policy of interviewing every known unmarried mother meant that its workers had seen all unmarried patients of the hospital's prenatal clinic and obstetrical ward, except those who may have concealed their unmarried status at the time of registration,

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Based on findings of a study completed under a grant from the Robert Sterling Clark Foundation.

and those cared for through the private or semiprivate services.

In the years 1956 and 1957, the prenatal clinic registered approximately 140–150 patients (married and unmarried) per month—a quota determined by bed space. The hospital has no minimal financial requirement but it does have a means test for clinical or ward care. Most of the patients came from the metropolitan area. Since the hospital policy was to give priority in registration to women who applied for care before the 7th month of pregnancy, nearly every obstetrical patient had had at least 2 months of prenatal care.

The hospital's definition of an extramarital pregnancy was adopted by the study: pregnancy in a woman who was not legally married to the father of the prospective child at the time she registered for prenatal care. Thus the study included not only unmarried women but women of divorced, separated, widowed, or common law status, and women who married after registering for prenatal care.

A total of 227 women pregnant out of wedlock fell under this definition and were thus included in the study. They constituted 6.7 percent of the patients receiving care in the prenatal clinic and obstetrical ward during the study period.

As found of unmarried mothers in other recent studies in New York City,[3, 4] these patients showed a wide range of social characteristics and revealed no pattern of an "average unmarried mother." However, there were a few factors which exercised a selective influence on the characteristics of the women studied at Mount Sinai Hospital. These factors included: the large proportion of Puerto Ricans in the population of the geographical area in which the hospital is located; the proximity of a maternity home which referred patients to the hospital, most of them white women and many from out of the city; and finally the hospital admissions policy which tended to exclude women who were very late in seeking prenatal care.

Social Characteristics

The ethnic distribution of the patients in the Mount Sinai study was almost a 4–3–3 ratio among Negro, white, and Puerto Rican women, respectively. The large proportion were under 25. While less than one-quarter of the patients studied were born in New York City, over four-fifths had been residents of the city prior to conception—100 percent of the Puerto Ricans, 95 percent of the Negroes, and 50 percent of the Caucasians. Almost half the women had been pregnant before, and of those who had, the larger percentages were in the Negro and Puerto Rican groups.

Regardless of ethnicity, the women showed widespread variation in size of the families they came from. Only one-third of them came from "intact" family units.

There were marked differences in the living arrangements of the women at the time of conception: about one-third were living with one or both of their parents, one-quarter with the putative father of the child conceived, and two-fifths with relatives or friends or alone. The majority of the white women were living with a parent or parents, Puerto Rican women with the putative fathers, and Negro women alone or with relatives or friends. The fact that so many of the Puerto Rican women lived with the putative fathers of the expected child reflects the higher frequency of consensual unions among Puerto Rican families as against Negro or white families. As expected, most of the younger girls of all three groups had been living with one or both of their parents.

About 40 percent of the women had made a change in living arrangements during their pregnancy. This was accounted for primarily by the white women, more of whom had left their parental homes for care in maternity homes.

Women who had had more than one pregnancy made up more than 40 percent of the total study group. Most of these were white or Negro women and over one-half of them were single. The other half were women in consensual unions, most of whom were Puerto Rican; and women who had been married but were presently separated, widowed, or divorced and involved in an extramarital pregnancy, most of whom were Negro or Puerto Rican. A majority of the multiparae had had more than one prior pregnancy.

The great majority of all the mothers were not dependent on public aid for support during pregnancy. They were either self-supporting or supported by parents, putative fathers, or friends. All of the nonresidents were supported through private resources. Only a little more than one-quarter of the total group were receiving assistance from the department of welfare, although a few more required such help later on for the support of themselves and their child.

Since the Negro and Puerto Rican women were prior residents of New York City, it can be assumed that their eligibility to use the clinic meant that their economic level was in the lowest third. On the other hand, the high percentage of white patients who had come from out of the city for care suggests the possibility that their use of clinic care reflected a change in economic status. A comparison between the socioeconomic factors of the nonresident and resident white women might be of interest.

Medical Findings

One of the study's major concerns was to identify the physical and medical course of women pregnant extramaritally and the implications of this for efforts to provide comprehensive care. We found that the Mount Sinai Hospital patients tended to be a somewhat more favored group, medically speaking, than those reported in other studies:[3,4] they began prenatal care earlier; they came for more prenatal visits; a higher proportion returned for post partum care; there were no maternal deaths among them; the perinatal mortality, although slightly lower, was not siginficantly different from the figures for all patients delivered at the Mount Sinai Hospital. This favorable position was probably accounted for, in part, by the hospital policy of usually not accepting women beyond their 7th month of pregnancy—a policy which undoubtedly contributed to less favored groups entering hospitals which did not have a comparable restriction.

Forty-two percent of the women had made their first visit to the prenatal clinic by the 20th week of their pregnancy, including the 9 percent who came by their 12th week. An additional 46 percent came between their 21st and 30th week—with the remaining 12 percent arriving after their 31st week. The median number of visits to the prenatal clinic prior to confinement was seven. The group, therefore, had had better than a minimal number of medical visits, but as a whole had not obtained the optimal.

Those who had lived in the maternity homes had the fewest prenatal visits. While the data showed that a high proportion of these women had arrived in New York City during the second trimester or earlier, there seems to have been a lag between their arrival and referral for prenatal care. This is another area needing further study.

When viewed ethnically the unmarried mothers at the Mount Sinai Hospital did not show a higher incidence of medical difficulties or medical complications than their married counterparts. This conclusion is based on a review of such indices as the incidence of nausea, anemia, and toxemia; duration of labor; weight gain; temperature elevation; comparison of actual delivery date with expected delivery date; medical difficulties during delivery; and fetal survival. Many of the medical problems were, as one would expect, not related to marital status, but rather to nutritional factors, lack of education, and social conditions.

More than half (57 percent) of the women returned to the obstetrics clinic for routine post partum care, and an additional 10 percent received post partum care at other clinics or as in-hospital patients. The remaining one-third did not return for any checkup. These last should be a source of concern because of the possibility of untreated medical problems.

Medical followup, as expected, was more usual among the residents of the city, regardless of their ethnicity, the transient white women apparently receiving least. Most of the multiparae sought medical care comparatively earlier, and returned for medical followup more frequently than the women who had not been pregnant before.

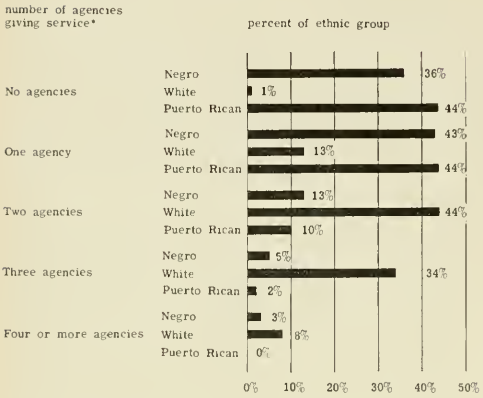
Those who failed to return for checkup did not receive the birth control information which is offered during the post partum visit at the Mount Sinai Hospital, a fact which suggests that an earlier exploration might be made of the patient's desire for birth control advice.

Use of Social Agencies

The study placed special emphasis on ascertaining information about the patient's planning for their newborn and their use of social services. The purpose was to learn whether these women are cognizant of the services available to them (if in fact they *are* available to all of them) and whether they are using services in accordance with their needs.

The hospital's social service department has adopted its policy of interviewing all unmarried mothers on the ward service on the premise that they are potentially in need of social services. The study showed that the application of this policy is hampered for certain ethnic groups by insufficient community resources being available to them. Varying cultural points of view regarding what constitutes illegitimacy and different patterns in the use of social agencies also contribute to the difficulties.

The social agencies which are used by the unmarried mothers receiving care at the hospital may be divided into two main groups: those serving unmarried mothers in particular (adoption agencies and maternity homes) and those which serve the general population. In the latter group are hospitals, including their social service departments,



DISTRIBUTION OF UNMARRIED MOTHERS
By Number of Agencies Giving Service

Mount Sinai Hospital, New York, 1956–57

*In addition to the Mount Sinai Hospital Service Department.

family and child-care agencies, court and corrective services, and the public welfare department.

In regard to use of social agencies, in general, the study revealed that 27 percent of the women were not known to any social agency other than the Mount Sinai Hospital Social Service Department. An additional 34 percent were known to *one* other agency; 22 percent were known to *two* others; and the remaining 17 percent were known to *three or more* agencies.

The variations in the use of social agencies were very pronounced when viewed ethnically. More than one-third (36 percent) of the Negro women were not known to any social agency other than that of the hospital, and 43 percent were known to only one other, usually the department of welfare. Only 21 percent were known to two or more. The Puerto Rican group was similar in this respect, except that an even larger proportion (44 percent) were not known to any other agency while almost the same proportion were known to one other agency, usually the department of welfare, and a lesser proportion (12 percent) to two or more agencies. [See chart.]

In contrast, the white group included only one woman not known to any social agency other than the hospital's social service department, 13 percent known only to one additional agency, and the remaining 86 percent known to two or more. This pattern in the use of social agencies by the white group reflected the simple fact that 56 of these women (76 percent of the white and 25 percent of the total group) were planning to make their infants available for adoption and were known to an adoption agency. In addition, 48 (85 percent) of the white patients were known to a maternity home and 20 (38 percent) were known also to a family service group.

While two-thirds of the women planned to take care of their newborns themselves, there were marked variations in regard to this according to ethnic groups.

Adoption was the primary plan among the white women, but only one Puerto Rican and one Negro woman planned adoption. This reflects, in part, the relatively small demand for children for adoption among these two ethnic groups. It may also reflect the general lack of agency services to encourage or satisfy application for Negro or Puerto Rican children to adopt. In view of the high incidence of infertility among Negro women, and the willingness of some to undergo surgical procedures which give only slight promise of correcting this condition, agencies might explore ways of encouraging adoptions among Negro families. Physicians also might consider advancing this suggestion to their infertility patients.

The majority of the Puerto Rican women planned to care for their out-of-wedlock children themselves within a framework of consensual union, or with financial assistance from a public agency. The Negro women for the most part tended to take their babies home to support them themselves, or with the assistance of a public agency. There was a general paucity in the use of guidance services in facilitating these plans—a situation which warrants further study both in regard to the availability and interpretation of services.

The pattern in which social agencies were used followed the pattern of care planned by the mother for her child. The use of social agencies by white women generally was focused on planning for the newborn; and by Negro and Puerto Rican women, on obtaining assistance in maintaining a family unit.

Among the 138 unmarried mothers who planned to keep their babies, 43 (31 percent) were known to the public assistance division of the department of welfare, while 7 percent were known to corrective agencies, 7 percent to family agencies, and 6 percent to child welfare services. Placement of the child in foster care was a minor resolution by all three ethnic groups.

There appeared to be no significant patterns by age groups in planning for the newborn or in use of social agencies.

The plans of mothers who had never before been pregnant were compared with those of mothers who had had previous pregnancies. Among the women who had had no prior pregnancies, 38 percent planned for adoption, 55 percent planned to keep their babies, 5 percent planned to place them in foster care. (In 2 percent the infant did not live.) A higher percentage of primiparae than of multiparae gave their babies in adoption, the highest proportion of primiparae being in the white group. Only 12 percent of the multiparae planned adoption while 76 percent planned to care for the babies themselves and 3 percent to use child placement services. (In 9 percent the infant did not live.) Their method of planning for the newborn was more closely related to their ethnicity than to the factor of parity. Multiparae who planned to keep their babies were more apt to be known to other social agencies than the primiparae who planned to keep their babies.

In examining the number of agencies to which primaparae and multiparae were known, we found that 30 percent of the women with no previous pregnancies had had no contact with social agencies other than the hospital's social service department, while 24 percent of the multiparae had had no other contact—obvious areas for further investigation. However, among those women who were known to social agencies, 65 percent of the primiparae were known to two or more agencies, as against 40 percent of the multiparae.

Some Implications

It is generally agreed that counseling services should be available to all unwed mothers.

Bernstein and Sauber[4] recommend that if sufficient personnel is not available to "reach out" with counseling services to all unwed mothers—particularly among the Negro and Puerto Rican groups (who seem to avail themselves less of social services)—priority attention should be given to the younger women who are having their first out-of-wedlock child. They also call attention to the possibility that "the dearth of community services for those Negro (and Puerto Rican) unwed mothers who do wish to place their children for adoption, of course, may influence the decision to keep the child" and point out that "what is needed urgently is counseling and other supportive services before and after confinement to help the Negro unwed mothers in their efforts to maintain a home for themselves and the child."

The Mount Sinai Hospital data tend to confirm these findings as well as the findings that social agencies are used by unmarried mothers for their specific objectives: those who plan to keep their child tend to seek outside help less frequently than those who want to place the child for adoption (and who may have come to New York City in order to bear the child and have it adopted in relative secrecy). The data also suggest the possibility that social agencies might play a more active role in reaching out to women whose repetitive pattern of pregnancy suggests emotional problems, to those whose personality limitations and social milieu make them more vulnerable to subsequent undesired pregnancies, and to those women who will be responsible for raising and caring for their out-of-wedlock children.

The finding that for a very substantial number of unmarried mothers the hospital social service department represents the only contact with a social agency suggests that the department needs to re-examine its services in many ways. It needs to consider whether it is working in a preventive capacity, whether it is frustrated in meeting existing needs by lack of community resources, and whether inherent attitudes in patients or professionals are deterrents to the use of social agencies. It also needs to re-examine the application of its guiding principle of "self-determination for the client."

The current interpretation of this principle results in help being given to the individual when she expresses a desire for service. Yet according to our cultural norms the unmarried mother is *ipso facto* a social problem. Social workers, therefore, need to exercise more initiative in educating the unmarried mother—and her family—to a realistic appraisal of the attitudes and obstacles she will inevitably encounter if she keeps her child, for which she may be quite unprepared, and with which she may be unable to cope. Such interpretation plus a surer availability of community services would then place the unmarried mother at a better vantage point for exercising realistic self-determination concerning her use of social services.

The data also suggest the need to work on establishing cooperative programing among the various agencies which deal with specialized aspects of the problems of the unmarried mother. These include the public agencies, such as the Department of Hospitals, the Department of Welfare, and the Housing Authority, as well as the voluntary agencies.

There were 12 women among the study group who, although unmarried at the time they registered for prenatal care, were married during their pregnancy, or immediately after the arrival of the newborn. Perhaps as a reaction to the problems resulting from the old-fashioned view that a forced marriage was the exclusive solution to the problem of an out-of-wedlock pregnancy, social agencies have tended to shy away from encouraging marriage unless it develops spontaneously. The number of women in the study group who married suggest that social agencies might well broaden their scope of interest in serving the unmarried mother to include the putative father and the families of both.

The apparent increase in members of out-of-wedlock pregnancies among young girls highlights the importance of providing more adequate and appropriate family life education in the schools with the assistance of social agencies. Girls who become pregnant out of wedlock have a special need for realistic information.

There is an additional problem for young Negro and Puerto Rican girls because of the ethnic pattern of taking the baby home. Since these youngsters receive little service, if any, from other social agencies, it becomes even more imperative that the hospital's social service department be especially active in preparing them for practical living and in attempting to initiate continuing community support and services. At the Mount Sinai Hospital, parental consent is required for obstetrical care of minors under 18. This requirement might be utilized more fully as an entreé to work with the families of the young girls.

At the time of conception, about two-thirds, 67 percent, of the Puerto Rican women were living with the putative father; most of them continued the same living arrangements during their pregnancy, and at least 43 percent expected to be fully supported by the putative father when the newborn arrived. While the Puerto Rican cultural pattern gives approval to the kind of stable consensual relationships which these figures reflect, these data suggest that social agencies might take a more active role in helping Puerto Rican families to accept the family pattern of the prevailing culture—marriage. Acculturation traditionally has been a service offered by social agencies to newcomers.

Incidentally, the language barrier has been an obstacle in reaching Puerto Rican patients who are usually expected to take the initiative in providing interpreter services. Further attention needs to be given to minimizing this barrier.

Hospitals have a special role in services to the unmarried mother in not only the provision of medical care but also in the extension of social services. Comprehensive care seems at this time somewhat more fully available to clinic and ward patients than it is to the private and semiprivate patients. Private physicians as well as doctors and social workers serving in hospitals are the connecting links which can effectively put these women in touch with appropriate community resources. Social action is essential for opening more community resources to Negro and Puerto Rican unmarried women.

The differences among unmarried mothers pointed up in this study indicate that there is no one primary approach to effectively reducing *all* out-of-wedlock pregnancies. On the contrary, the findings suggest special approaches are needed for each of the various subgroups of unmarried mothers, incorporating a proper balance between individual counseling and work on a broad social front. Followup studies are needed for establishing priorities and developing more effective techniques.

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[1] U.S. Department of Health, Education, and Welfare, Public Health Service, National Office of Vital Statistics: Illegitimate births; United States, 1938–57. Vital Statistics Special Report, Vol. 47, No. 8, Sept. 30, 1960.

[2] ———: Vital statistics of the United States, 1959; section 3, natality statistics. 1961.

[3] Pakter, Jean; Rosner, Henry J.; Jacobziner, Harold; Greenstein, Frieda: Out-of-wedlock births in New York City. *American Journal of Public Health*, May and June 1961.

[4] Bernstein, Blanche; Sauber, Mignon: Deterrents to early prenatal care and social services among women pregnant out of wedlock. Community Council of Greater New York for the New York State Department of Social Welfare. New York, June 1960.

The March–April 1963 issue of CHILDEN will be concentrated on the needs and problems of unmarried mothers.

THE PERCEPTION OF CHANGE IN AGGRESSIVE CHILDREN

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THE ACCURATE assessment of change following therapy is a chronic problem for clinicians. When the normal complexity of the therapeutic relationship is coupled with the natural fallibility of human observers of change, the result is such uncertainty about the efficacy of therapeutic methods that continued clinical work must proceed, supported either by faith or by a biased scorekeeping that records successes in more detail than failures. This seems to be borne out by a recent exploration, undertaken by the University of Michigan, of the varying perceptions of parents, teachers, therapists, and children in regard to the effects of a summer spent by the children in a therapeutic camp for emotionally disturbed boys. The exploration was carried out with funds provided by the Michigan legislature for service and research in the utilization of human resources.

The attempts at assessment, which were made 6 months after the camp experience, revealed a tendency for all respondents to report more positive change when assessing on a broad general level rather than on specific modes of behavior. This experience suggests not only that researchers need to be specific in looking for changes in behavior, but also that more precise determinations of effectiveness might be achieved through studies in which elements of therapy are controlled.

The children involved were those who for 7 weeks in 1960 attended the University of Michigan Fresh Air Camp—a clinical training institution for graduate students in psychology, social work, group work, and psychiatric nursing. Referred to the camp by a child guidance clinic, a detention home, or a mental hospital, the average Fresh Air Camper has an unusually aggressive, antisocial orientation to life. The treatment he receives at camp is a combination of individual and group therapy focused on the problem of the management of aggression.[1, 2]

In the followup study the research investigators queried the campers through their therapists and gathered information from their mothers, their therapists, and their teachers on their observations of the children both before and after camp.

The Campers' Perceptions

The questionnaire to which the campers responded consisted of a brief series of open-ended questions which, in most instances, were read to the camper by his therapist 6 months following his stay at the Fresh Air Camp. Responses were gathered from 75 former campers.

The camp program provides a variety of exciting activities to substitute for the thrill of the typically antisocial or delinquent pastimes of the children. When queried, 93 percent of the children had their most poignant memories of the camp's activity program while the remaining 7 percent fondly recalled their fellow campers, their counselors, and members of the senior staff, proportionately in this order. If one looks to conscious recall as evidence of the impact of the camp on its clients, it does not seem that the numerous therapy sessions the children had in the camp lingered longest in the foreground of their memories.

When asked about which aspects of camp life provided the greatest source of difficulty, 48 percent of the children interviewed reported that their greatest trouble came from the other children in camp; 23 percent, from the activity program; 16 percent, from the counselors; and 13 percent, from the senior staff. These reactions parallel closely the camp staff's observations of their children's actual behavior.

Despite their awareness of the emotional problems they experienced in the camp setting, 90 percent of the children said they felt that the camp helped them in adjusting to their problems and 85 percent of them reported that, as a consequence, they are getting along better this year. However, their perception of what it means to be helped and to get along better tended to be very narrow and they were more optimistic about their social and emotional plight than the adults who judged them. Many of the children who reported substantial gain were at the time deep in social difficulties.

The children were aware of the therapeutic intentions of the camp and they evaluated the various sources of therapeutic assistance without hesitation. The majority (56 percent) described the camp activity program as the camp's most curative feature. The camp staff was accorded some therapeutic recognition by 32 percent of the children. Therapeutic benefit was ascribed by 12 percent of the children to the efforts of their fellow campers, though this degree of assistance was not notably visible during the camp session. There had, of course, been times when peers provided emotional support at the height of a social crisis and instances in which a word of caution or consolation from an admired cabin-mate carried astonishing weight.

Table 1

TEACHERS' RATINGS OF CHANGE IN CHILDREN'S BEHAVIOR FOLLOWING CAMP

classroom behavior	number of children	percent of children changed		
		more	same	less
Disruptive in classroom	44	19	36	45
Aggressive to other children	43	15	35	50
Accept verbal control	39	29	51	20
Can be reasoned with	40	55	35	10
Can stick to a job	38	36	55	9
Trying to get along	43	65	23	12
Friendly to adults	40	47	47	6
Accepted by other children	42	38	55	7

In looking over the children's responses it becomes apparent that the campers were responding to their therapists (and a set of loaded questions) in a socially approved fashion. In almost prim and proper fashion they said what they apparently expected others wanted them to say. Thus, we are faced with the alternative of accepting these responses at their face value or rejecting the campers as accurate and insightful recorders of their own difficulties and of the therapeutic efforts made in their behalf.

The Parents' Perceptions

The opinions expressed by the campers bear a striking resemblance to those reported by their parents. The parents were asked to report what their sons had said to them about camp, particularly whether they had enjoyed it, whether or not they had liked the other boys, and whether they had liked the counselors and members of the senior staff.

Ninety percent of the parents said that their sons reacted positively to the camp while 9 percent said that their children did not like the other children at camp. In light of the actual behavior of the children at camp and their chronic complaints there about the actions of the other children, these results hardly seem based on a realistic appraisal of the boys' former feelings. It may be, however, that after the passage of 6 months little remained to the children of their once bitter feelings.

In order to press for a more accurate appraisal of the program's effect, the parents were told that not all boys benefitted equally from the therapeutic regime at camp. Asked to estimate the degree to which their own child benefitted, the parents responded: "a great deal," 48 percent; "somewhat," 39 percent; "no effect," 13 percent.

Just as a glass can be described as half full or half empty, this parental estimate can be interpreted as meaning either that 87 percent of the parents felt that their children had an improved adjustment following camp or that 52 percent (the sum of "somewhat" and "no effect") returned in much the same psychological condition as at the beginning of the summer.

Perhaps the important observation of these results is that these figures, while generally favorable, reflect a much less enthusiastic record of our therapeutic efforts than the reports of the children. It may be absolutely essential for parents to believe that change—even a slight one—has taken place. The expectation that the child will be a different person psychologically may be necessary to provide the impetus for an improved pattern of response between parent and child.

The Teachers' Perceptions

A more demanding test of therapeutic change occurs in the school setting. Despite the usual good will of teachers toward their pupils—especially at the beginning of the semester—it must be kept in mind that each of our campers had something of a notorious reputation from the past year. He was well-known to the teacher as a "problem child."

To accomplish its goals, the school must in many ways be a less charitable environment than the child's home or his therapist's office. Teachers tend to be less involved emotionally with such children than their parents or therapists, and the degree of disruption that can be tolerated in a classroom is much less than that in most other settings. Therefore, the teachers' ratings can be a sensitive indicator of the quality of the current behavior of the child.

The number of children on whom teacher ratings were gathered was much lower than the number on whom ratings were garnered from parents or therapists, since to make a rating a teacher had to have had experience with the child both before and after camp. In a sample of 41 children, teachers reported a positive change in behavior for 61 percent; no noticeable change for 27 percent; and a negative change for 12 percent. Thus the teachers on the whole were less favorably impressed by the camp's effectiveness than the parents.

In an effort to secure a more specific picture of changes in behavior, the teachers were asked to make ratings along a series of concrete dimensions. [See table 1.] When we moved to securing estimates of specific behaviors, we found a less positive view of the change in former campers. The degree of improvement exceeded 50 percent in only two instances in this list of behavior items.

The most frequent specific behavior improvements reported were in trying to get along in school (65 percent), ability to be reasoned with (55 percent), and being friendly toward adults (47 percent). The percentages of boys for whom these aspects of behavior had deteriorated since the previous year were very low; 12, 10, and 6 percent, respectively.

These improvements are heartening since a considerable portion of the therapeutic work at the Fresh Air Camp is directed at having the child experience nonpunitive, understanding, and accepting relationships with mature and well-balanced adults. It is always difficult to assess the power situation or provocation to which a child will be exposed in the classroom and thus to predict how he will behave there.

In regard to the children's relation to their peers, the teachers rated 50 percent of the 41 children less aggressive to other children, but only 38 percent as more accepted by other children. Perhaps the aggressive child's peers are adhering to the maxim "once burned, twice shy" and are not yet ready to make an unqualified acceptance of the seeming reform of their erstwhile tormentor.

The children's ability to "stick to a job" was reported as least altered following the camp experience, but the teachers did rate 36 percent of the children improved in this respect. Work habits tend to be fixed firmly as a style of life, but improvement in general behavior, more cooperation with adults, and better acceptance by peers ought to be powerful forces toward making it possible for a child to stick to jobs from which he was diverted in the past by preoccupation with anti-authority activities. However, it would be highly unrealistic to expect a more widespread improvement than that reported by the teachers, and even this seems somewhat optimistic. A child more at peace with the authority figures in his environment may still be unable to stick to the arithmetic he only dimly understands.

The Therapists' Perceptions

Seventy-five percent of our campers had been in psychotherapeutic treatment between 6 months and 2 years prior to attending the camp and, on the average, therapeutic contact occurred once a week. Following the camp experience, about 80 percent of the campers resumed some therapeutic treatment. The 20 percent not in treatment following camp represent children who showed clear improvement and children removed from the agency's jurisdiction.

The therapists of the 63 campers who remained in treatment reported some change in both the character and intensity of the relationship among 44 percent of these children.

To the question *how does his current treatment differ from what he received prior to camp?* the replies indicated that the treatment was more intensive for 25 percent of the children; less intensive for 19 percent; and no different for 56 percent. Thus the absolute gain in therapeutic intensity amounted only to 6 percent of the sample population. (We have assumed that an increase in the intensity of treatment is a desirable condition and signifies the likelihood of greater therapeutic progress.)

Because "intensive" may be too broad and inclusive a term to reflect what has actually happened to the therapist-patient relationship, more specific ratings were requested. In regard to the *pace* of treatment, we found a different level of response concerning the 54 children on whom reports of this nature were obtained. The therapists reported that the camp experience *changed the pace of treatment* for 70 percent of these children, but not for the remaining 30 percent. They reported a *hastened pace* for 90 percent of those in whom a change of pace was noticeable and a *retarded pace* for the remainder.

These subjective estimates of the therapists indicate, at least, that the movement toward solution of the child's problem has in most instances moved off dead center. "Hasten" in this context probably refers to the feeling that material important to the child's dynamics is being uncovered.

The therapists also reported that 52 percent of the children in therapy perceived the post-camp therapist-patient relationship as potentially a more helpful one and 54 percent displayed a greater willingness to discuss their feelings. These changes in the child's attitude seem to be the basic reasons for the therapists' feeling that the pace of the treatment has been hastened.

Further observations of the therapists' estimates of specific changes in therapy are reflected in ratings of change in the child's behavior. [See table 2.]

Thus the therapists' findings also reflect a generally optimistic view of the gains in emotional stability experienced by the campers. That progress in therapy is not always reflected in the daily behavior of patients became apparent from replies to a question of whether or not the children had been in any social difficulty since camp. Among the 62 campers for whom responses were received in this regard, 54 percent were reported by the therapists as having been in such difficulty. Progress in therapy may be judged in terms of the goal of self-understanding and impulse control. However, a considerable gap may exist between a beginning verbal understanding and full control over one's response to a flood of stimuli from a highly unsatisfactory home life and social environment.

The therapists' views of the changes in their relationship to their clients were accompanied by a generally positive perception on their part of the camp experience. On the whole, they reported that the campers held highly positive attitudes toward other campers, the activity program, and the camp staff.

Influences on Perceptions

Evidently attempts to assess overall change in a child following therapy generally meet with responses leaning in the direction of perceived progress for the patient. When the categories are limited to the equivalent of "good," "bad," and "indifferent," the child patient, his mother, his teacher, and his therapist are all inclined to mix hope with reality and to give the therapeutic efforts the benefit of the doubt. When pressed to report improvement or regression for specific aspects of behavior, the average estimates of the efficacy of treatment decrease in a regular fashion. The very regularity of this phenomenon, which cuts across respondents, suggests that evaluative research which relies on global impressions is likely to obtain data which mask the true nature of the degree of change. The forces which influence observers to see progress and growth in patients are also likely to influence their assessment of the behavior and attitudes of emotionally disturbed children who have not been exposed to therapy.

There are a number of reasons why this therapeutic "halo" effect occurs. First is the fact that when children have been unusually aggressive—as were the children in this study—their superficial response to therapy might give the impression of considerable change. The *treatment* of aggression is, in a sense, a misnomer. A more accurate description would be one that refers to the *treatment of hostility* and *the management of aggression*, since hostility is an emotional state which may or may not manifest itself in overt behavior. As Slavson[3] has indicated, its appearance may be only in the form of excessive passivity, pathological withdrawal, or merely a lack of cooperation. The manifestation of hostility in the form of aggression may be only a sporadic event, which therapy may control rather than cure; the underlying emotional state may be suppressed and the "cure" be more apparent than real. The evaluation of the therapy of aggression is thus made perilous by its highly symptomatic nature.

A second source of fallibility in human assessment of change lies in what is called the placebo response. In medicine, Diehl, Baker, and Cowan[4] reported a 55 percent reduction in common colds among subjects given a cold vaccine, and a 61 percent improvement among members of a control group who got injections of isotonic sodium chloride solution. As Rosenthal and Frank[5] report, all forms of psychotherapy yield successful results with some patients and the evaluation of therapeutic measures ought to be designed in such a way to provide some control for this placebo effect.

Every psychotherapy has in common the therapist's relationship with a disturbed person. Even the physician in general practice, who has had no formal training in things psychological, reports a psychological improvement in his patients as a result of his ministrations. If the placebo effect is essentially a function of the patient's conviction that the therapy will help him, then an assessment of the impact of particular techniques can never be untangled from the total situation.

In light of these observations it ought to be possible, as Watterson has suggested,[6] to design a study of psychotherapy that would contain the essential elements of placebo therapy in physical medicine. This would require convincing two groups of patients that they were getting identical treatment while actually exposing only one to that aspect of treatment thought to be curative. If, for example, a therapist thought reassurance to the patient might be the important variable, both groups would get treatment but only one would be exposed to systematic reassurance on a planned basis.

This technique would require some precise statement of hypotheses regarding the essential ingredients of treatment if comparisons between the groups were to be made. Imber and associates[7] have suggested studying specific dimensions such as *amount of contact* with the patient in this manner. To be sure, this confines measurement to a single variable in a complex situation but it frees experimenters somewhat from the ethical problem of denying treatment to patients simply for the sake of research. A normal patient load could be carried by the therapists who would carry on treatment in his usual fashion, subtracting for experimental purposes a single ingredient of the process for those patients in the control group.

A further series of pressures issue from the set of expectancies created in respondents who know that the child on whom he is reporting has undergone intensive daily therapy for a period of 2 months. Even the smallest evidence of change in a positive direction would tend to confirm the expectations of parents, teachers, and therapists that the child's behavior would be altered. In most instances we might expect those closest to the child to resist evidence that the child is no different despite this experience.

In addition to this perceptual set which would let *different* behavior be seen as *better* behavior, many other forces exert pressure in the direction of regarding the camper as changed. The 2-month separation from his normal environment would tend to revitalize the child's relationships with others since even temporary relief from mutual provocation and frustration is apt to give both parties an emotional breather and alter their readiness to respond destructively to one another. Attendance at camp also would increase the therapeutic investment in the child by stimulating teachers, therapists, and parents to take a closer psychological scrutiny of him. This closer examination may reveal qualities and characteristics which always existed in the child but because they are noticed now for the first time are attributed to his therapeutic experience.

The confirmation of expected change, even in these unreliable ways, may initiate a circular process of changed action and reaction which tends to produce a more harmonious pattern of interrelations. One

Table 2

THERAPISTS' ESTIMATES OF THERAPEUTIC CHANGE FOLLOWING CAMP

type of change	number of children	percent of children		
		yes	no	don't know
Perception of adults changed positively	70	59	21	20
Social skills improved	70	64	23	13
A healthier balance between impulse and expression	70	64	26	10
Seems happier, with more positive feelings about himself	69	62	27	11

would expect that the resulting decrease in pressure on the child would free him from some of his need for reactive negative behavior. If no other circumstances were to interfere with this process, some children might be expected to exhibit a remarkably changed pattern of behavior. Indeed this is often the case.

The effect on the child's emotional surroundings of perceptual change in the child-adult relationship would undoubtedly be most permanent in the child whose problem is not part of a deeply rooted neurosis or is not subject to continued environmental provocation. In children whose problems are so involved, the change would be apt to be short-lived, and the pressure to misbehave would force a revision of the adults' favorable perception toward a conviction that the child is incorrigible. Once adults important to a child have come to perceive the child as unimproved, his situation worsens noticeably. The despair felt by the adults is soon communicated to the child through their responses to him and he soon reacts in kind. At this point teachers, parents, and therapists become more willing to consider drastic therapeutic measures involving gross alteration of the child's environment.

Some Conclusions

To ask parents, teachers, and therapists to act as objective observers of a child's behavior is to make too great a demand on them. In reality, of course, no rater is capable of separating cause and effect or of assessing the impact of therapeutic camping apart from a child's other experiences. Since in this study every child was in treatment before being sent to camp and continued in a similar relationship following camp, we have, at best, an assessment of change that cannot easily be traced to a single source. The raters actually could not determine which of the child's responses were the result of normal development; and they were hard pressed to distinguish fundamental change from the strangeness which usually follows a separation of several months.

At least two conclusions seem apparent from the interpretation of this study:

1. The use of perceptions in the assessment of therapy is a complex process that requires more than a global and superficial approach. Specification of the exact behaviors that one might reasonably expect to change as a consequence of therapy is a necessary part of the appraisal.

2. Research reports which rely on estimates of the overall efficacy of therapy gleaned from clinic and agency reports present conclusions which may be more apparent than real. It is possible to design an experiment in which much the same kind of perceptual alteration toward children who had *not* had therapy could be brought about in parents, therapists, and teachers.

It is not unusual for teachers and parents to report an improvement in the behavior of a difficult child following diagnostic testing. Because of the relationships such a child experiences with the significant adults in his life, changes in their perception of him have a definite impact on the decisions he makes about behaving or misbehaving. While fundamental personality reorganization is unlikely to occur in a child during short-term therapy, the treatment methods may achieve a potent effect by forcing a perceptual reorganization on those who must deal with the child every day.

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[1] McNeil, E. B.: The background of therapeutic camping. *Journal of Social Issues*, Vol. 13, No. 1, 1957.

[2] Morse, W. C.: An interdisciplinary therapeutic camp. *Journal of Social Issues*, Vol. 13, No. 1, 1957.

[3] Slavson, S. R.: The treatment of aggression. VII. Through group therapy. *American Journal of Orthopsychiatry*, July 1943.

[4] Diehl, H. S.; Baker, A. B.; Cowan, D. W.: Cold vaccines; further evaluation. *Journal of the American Medical Association*, Aug. 24, 1940.

[5] Rosenthal, D.; Frank, J. D.: Psychotherapy and the placebo effect. *Psychological Bulletin*, July 1956.

[6] Watterson, D. J.: Problems in the evaluation of psychotherapy. *Bulletin of the Menninger Clinic*, November 1954.

[7] Imber, S. D. et al.: Improvement and amount of therapeutic contact: an alternative to the use of no-treatment controls in psychotherapy. *Journal of Consulting Psychology*, August 1957.

If facts can be discovered and set uncolored in true proportion before us, can we not trust ourselves to understand and work out the remedies? There is one answer in the long run—and it is affirmative.

Julia C. Lathrop, first Chief of the Children's Bureau, in an address before the National Conference of Social Work, 1921.

A study of health attitudes and practices in low-income groups suggests . . .

SOME CONSIDERATIONS IN CHANGING HEALTH ATTITUDES

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EARLY IN 1958, the Department of Preventive Medicine and Public Health of Howard University College of Medicine undertook a 3-year study of the social and cultural factors which influence the attitudes, knowledge, and behavior of low-income families in regard to health. The study, which was financed by Federal grants from the National Institutes of Health, Department of Health, Education, and Welfare, was undertaken in an attempt to throw light on such questions as:

1. What is the general level of knowledge of low-income families about local preventive health services, and what use do they make of these services?
2. What are some of the factors influencing knowledge about and use of such services, and distinguishing the informed person from the uninformed?
3. What leads can be obtained on how the uninformed, in particular, can be reached and influenced?

The complete report of the study[1] consists of 19 chapters in 3 mimeographed volumes with 202 tables, but it does not answer all of these questions fully. However, it does provide some information and suggestions which may be of value to public health practitioners.

The primary area of study consisted of two census tracts in the northwest part of Washington, D.C., adjacent to Howard University. Nearly 100 percent of the inhabitants of this area are Negroes. The families for the study sample were selected on the basis of every eighth family in the two census tracts.

For comparative purposes, a number of white families were also selected for study from blocks in another low-income area suggested by local social agencies, and an effort made to match them with the Negro families on the basis of occupational level of the family head and the presence or absence of children under 18 years of age. Final analysis, however, showed that the Negro and white families differed in these and other respects. Therefore, the differences between the two groups in the findings should only be considered as possibly indicative of differences arising from varied experiences. Data on the families were gathered by personal interviews, averaging 2 to 4 hours in length, with one adult member of each household. Seventy percent of the persons interviewed were women; half were heads of households. A total of 408 families were studied, 310 of them Negro, 98 of them white.

In both groups the families were largely of southern origin. Almost 100 percent of the Negro and three-fourths of the white family heads came from the South, about half of each group having been born in the District of Columbia, Maryland, or Virginia.

The great majority were long-time residents of Washington, the preponderance having lived in the District of Columbia 20 years or more. This is, therefore, a study of a stable urban population, rather than of a transient or newly arrived group.

The educational level of those interviewed was low, nearly half of the respondents (both Negro and white) having had no more than 8 years of education. By occupation, almost half the Negro family heads but only a tenth of the whites were in common labor or service jobs. By contrast, over half the whites, but only a fourth of the Negroes, were in white-collar or craftsmen jobs. Almost three-fourths of the Negroes and half the whites had total family incomes of under $4,000.

Following are some of the study's general findings.

Attitudes and Beliefs

General Attitudes. Good health is regarded as important by these families. The degree of importance accorded it is apparently not markedly affected by such personal or family characteristics as education, income, occupation, and place of birth.

The steps suggested by the respondents for staying in good health nearly always had to do with good health habits, such as proper food, living moderately, and getting sufficient sleep, rest, and exercise. Immunization, early diagnosis, and prompt treatment of illness or defects were rarely mentioned as being of value to positive health.

In answer to queries about habits of cleanliness, the majority of those interviewed said they thought frequent bathing was advisable. Hand-washing was mentioned by most of them as desirable before eating and preparing foods but was mentioned only by a few in connection with other occasions, such as after using the toilet or handling soiled objects. These responses were not markedly different among respondents differing in selected personal and family characteristics.

With few exceptions, these families do not regard race as a factor in maintaining personal health. Race was, however, reported by 11 percent of the respondents of each racial group as having a bearing on certain illnesses, such as tuberculosis and syphilis, and by larger proportions, especially among the white respondents, as being related to the kinds of health problems a community has. Many Negroes among those of the higher educational and economic levels shared this last opinion.

Nutritional Beliefs. Most of these families still believe in a great many food fallacies which were exploded years ago. The major fallacies to which they cling are that frozen and canned foods are nutritionally inferior to fresh foods, that citrus fruits cause acid in the blood, that red meats have an ill effect on hypertension, and that fish is valuable as a brain food. Certain characteristics, such as the lower age of the family head, the higher educational level of the respondent, and the family's prior residence in an urban area minimize the acceptance of these food fallacies.

Most respondents of both races showed deficient knowledge in regard to healthful foods. Of the four food groups essential to an adequate diet, only one, vegetable-fruit, with a four-to-one ratio in favor of vegetables, was mentioned as essential by as many as two-thirds of the respondents. The bread-cereal group was seldom selected as healthful. Fruits and eggs as specific foods were not given high priority. Collards, turnip greens, and kale were prominent among the foods mentioned by Negroes as having high health value, but were not mentioned by a single white respondent.

Negro much more frequently than white respondents emphasized pork as a harmful food, and also as the food with which they most commonly had trouble.

Periodic Health Examinations. While much lip-service has been given in this country to the value of the periodic health examination and the need for its wider use, it is an accepted fact that the practice is hardly adhered to throughout the Nation. Low-income families who would benefit greatly by its use are no exception in this respect. The overwhelming majority (about 95 percent) of the persons interviewed said they thought the physical checkup was important. However, the proportion of those who had one was not of the same order. Furthermore, belief or nonbelief in the physical checkup was not associated with its use. There were just as many believers among those with low as with high utilization.

Most of the families did not know what procedures are generally included in a "complete" health examination. The respondents mentioned an average of 2.5 procedures they thought were included, the number increasing slightly with their educational level. The procedures mentioned most commonly were blood pressure measurements, blood tests, X-rays (except chest), and urinalysis.

The majority of respondents of both races stated that their decision to obtain a physical examination would be determined by the presence of early symptoms. The majority of the Negro families, unlike the white families, apparently would turn more readily to the hospital or clinic for examination than to a private physician. Unfortunately comparative analysis on the basis of income was not made.

Knowledge and Use of Services

Governmental Health Services. The image which many of the families in these low-income neighborhoods have of the local health department and other official agencies is somewhat blurred. The health department is looked upon more as a dispenser of medical care than of preventive services. Some of the respondents said they thought that the department provided periodic health examinations, chest X-rays, blood tests, and immunizations, but nobody mentioned such broad areas of services as health education, dental care, and maternal and infant care. The health department was frequently, but erroneously, reported to provide garbage and trash collection.

Most of the respondents did not know where or how the services they mentioned could be obtained. This may have been due in part to the fact that although these families were long-time residents of the city, most of them had not had much contact with the health department and its centers or, if they had, they were not aware of it. Those families which had availed themselves of the department's services—a minority of the total—had done so for medical treatment in the public hospital's outpatient clinic or for delivery, rather than for preventive services.

The ignorance of most of these families in relation to the majority of services available extends not only to the health department, but also to the departments of public welfare and vocational rehabilitation, the last being the least known. On the whole, the respondents knew more about hospitals than health centers and child health clinics. However, as would be expected, families with children under 6 years of age were better informed about the child health centers than other families.

Nongovernmental Health Agencies. For more than half a century nongovernmental health agencies have labored in the field of health education and health services, but low-income families, at least those in the neighborhoods studied, apparently have not been reached by these efforts. The respondents were queried about seven voluntary agencies which have health programs in the city: the Visiting Nurse Association, and local chapters of the American Cancer Society, American Heart Association, National Tuberculosis Association, National Foundation, American Social Health Association, and the National Society for Prevention of Blindness. The best known was found to be the Visiting Nurse Association, three-quarters of the respondents having mentioned at least one of its activities. Less than one-fifth of the respondents knew about the activities of the least known of these agencies. As with the official health agencies, the agencies' medical treatment activities rather than their preventive services were most frequently mentioned.

The majority of the respondents reported that they had not received health education materials from any of these voluntary agencies. If they had, they apparently had forgotten about them. Curiously, the Visiting Nurse Association, which was the agency best known by these families, was, except for one other agency, the least frequently mentioned in terms of literature received. Nevertheless, there appears to be a favorable relationship between acquisition of health literature and knowledge of the agency, since among those respondents who received literature from an agency a higher proportion knew about its activities than among those who had not received any literature. Education and income were the characteristics of the respondents most closely related to the level of information they had about the voluntary agencies. Knowledge about one agency also appeared to enhance acquisition of information about other agencies.

Other responses in relation to voluntary agencies seem to suggest that the absorption of health infor-

A visiting nurse instructs a new mother in infant care. This is the type of health service which was found to be known best among the low-income families in the study reported here.

mation is facilitated if it has been dispensed over a long period of time; if it is brought close to the families who need it; and if there is an object or person with which the information can be identified.

Preventive Health Services. Preventive health services are the key to the maintenance of the health of any community, but these must extend to all segments of the population. While a majority of the children in these families were reported to have had immunizations for diphtheria, whooping cough, and smallpox, a sizeable proportion were reported not to have been immunized against these diseases, thereby constituting a threat to the community. This was particularly true of smallpox, but the respondents may not have identified vaccination with smallpox prevention.

Although this study was begun just after a widespread immunization campaign for Asian influenza, only 30 percent of the respondents reported that at least one adult in their family had received the vaccine. The performance for poliomyelitis was better than for influenza, though not good enough. Almost 50 percent of the people in these families had received one or more injections of the Salk vaccine.

Many of the adults in these families had undergone four screening procedures—chest X-ray, eye examination, blood test, and urinalysis. For each procedure, however, there were large percentages of families in which none of the adults had ever been examined. Chest X-rays had been most generally experienced. This was probably due to the longer history of antituberculosis campaigns and to the ease of identifying this process and its accessibility in the neighborhood.

Although the communities under study have a better than average dental health service available to children, approximately 30 percent and 15 percent of Negro and white families, respectively, reported that none of the children had had dental examinations.

Use of Physician. The relationships of patient to physician are complex and difficult to evaluate. Nevertheless, an effort was made to analyze certain aspects of such relationships. The majority of the respondents said they were ready to turn to medical personnel in the case of serious illnesses, but almost a quarter said that if medical care failed to bring immediate relief in the first instance they would turn to religion, family, or friends. Many others seemed to be at a loss as to what they would do. These responses varied for certain groups: those who had had no high school education and those whose recent residence had been in the South were more likely to say that they would consult nonmedical sources than the better educated or than those born in the District of Columbia or in the South, but had lived in the District for 20 years or more.

About one-fourth of the respondents of both groups reported having had difficulties with physicians such as inadequate treatment, inconsiderate behavior, unsatisfactory referral, difficulty in obtaining service, and high cost. However, a higher proportion of the whites reported difficulties over the acquisition and cost of services. Families in which the head was in the older age bracket; whose occupation was above that expected at their educational level; who were from the South but had lived in the District for 20 years or more; or whose head had never attended high school reported the least difficulties.

The Negro families listed three major qualities which determined their selection of a physician: his training and experience, his reputation, and his display of interest and concern, in that order. The white families mentioned these three, but were not as concerned about reputation, and gave greatest emphasis to availability and low fees.

The quality of maternal and infant care has been considered the best gauge of health appreciation and progress in a community. Therefore, families which included two or more living children—116 families—were subjected to an additional questionnaire in order to determine whether the experience gained with the first pregnancy and child favorably affected the most recent. The responsibility for child care in these families, as in most families anywhere, lies primarily with the mother. However, when there is sickness, the proportion of husbands who aid in the care increases. How extensive this aid is cannot be stated on the basis of this study.

In most of these families the various aspects of prenatal care (including the month or trimester the expectant mother was first seen by a physician, the person she consulted for care, and the reason she first visited the physician) worsened between the mother's first and last pregnancy, or showed very little improvement. The majority of the mothers said they did not go to the physician or clinic on their first visit primarily to obtain prenatal care but for other reasons. They also said that their knowledge about pregnancy and baby care had not perceptibly increased between their first and last confinements, even though for all of them the time interval was at least 5 years. Their source of information in the first instance was in most cases medical personnel, family, and friends. For their last pregnancy, this came from their own knowledge and experience.

Unlike the experience of maternal care, the *behavior* of these families in reference to medical care of children showed some improvement between the first and last birth. This was true of the frequency of medical visits during the first year of life, the age of the child at the first medical visit, and the reason for this visit.

Prepayment for Medical Care. The prevalence of any type of health insurance was lower among Negro than white families. The insured white families more often reported than did the insured Negroes that they had secured coverage through their jobs or trade unions. They felt that the insurance had helped them to secure needed medical care. In general, Negro families had less health insurance coverage than did white families, even when comparisons were based on families which were approximately matched on important demographic characteristics, such as income, family composition, and occupational and educational levels of the family heads. However, the Negro families who had insurance had higher standards of health behavior than those without. For example, a higher proportion of insurance holders obtained physical checkups and had higher scores on the questions relating to health information and behavior.

Living Patterns

Social and Religious Participation. It was hoped that through inquiries into the formal and informal social relations of these families pertinent clues would be obtained for developing more effective health education approaches. The results, although not startling, are suggestive. For example, three-fourths of all the family heads reported no organization membership. Such memberships were more frequent among those of the higher economic, occupational, and educational levels, and increased with the age of the family head. With respect to the type of organizations to which the families belonged, Negroes most often reported church-related groups and fraternal lodges; whites, lodges, civic and citizens groups, trade unions, and professional and business organizations. Membership in church-related bodies was more closely associated with age (over 60) and education (no high school) than with any of the other variables. In general, the health information and behavior score was positively related to organization membership but not to participation in informal social relations.

In regard to religious participation, half the respondents, both Negro and white, reported *frequent* church attendance. However, those most active in church-related affairs seemed least informed on health matters for various measures of church participation were negatively related, to a significant degree, to the health information and behavior score. Church attendance was positively related to increase in age, low occupational status, high economic level, and long-term residence (over 20 years) in the District of Columbia. A small proportion of the respondents reported that the churches to which their families belonged offered various kinds of health-related programs. While very few of the respondents regarded their religious practices as a first line of defense against illness, the fact that some did look to their churches or to the clergy as a source of help with illness suggests a possible channel for health education.

Communication Habits. Respondents who reported reading health material regularly in newspapers or magazines were twice as likely to have a high health information and behavior score as those who did not. A greater proportion of those with high health information and behavior scores had noticed health material in every medium (TV, radio, newspapers, and especially magazines) than of those with low scores. Again the high scorers reported that the media providing the most helpful information on health and illness were newspapers and magazines, while those with low scores preferred TV. Reasons mentioned by the respondents for choosing a medium as most helpful were in order of frequency: (1) its availability; (2) its vividness and clarity of presentation (mentioned more often by the low scorers and attributed most often to television and magazines); and (3) its authority and accuracy (mentioned more often by the high scorers and attributed chiefly to magazines and newspapers).

Implications of the Study

This study as a whole has two major implications for all health workers. The first has to do with the *variations* found among low-income families of either race, and the second with the *approach* to their health education.

The responses of both Negro and white families strongly suggest that in a low-income area variations exist among families of the same race not only in regard to income, but also in the range of health knowledge, health habits, health attitudes, and the utilization of health services. Thus it becomes apparent that families living in low-income areas cannot be considered as a homogenous group to which uniform approaches and procedures can be applied.

It is the fashion these days to talk rather glibly about the hard-to-reach segment of the population as though this were synonymous with the low-income population. If this attitude persists among public health people, programs developed for such groups are likely to end in failure. Multifaceted programs have to be developed in order to appeal to the range of interests among the people in these areas. This is especially true in many urban communities, North and South, where Negro families of varied social and economic levels have had to remain in overcrowded and otherwise disadvantaged residential areas because of racial discrimination in other areas.

Health education as practiced in the District of Columbia and most other communities throughout the past 50 years has favorably affected people's health practices, but not as much nor as rapidly as might be desired. Health education today must change its procedures from the slow and uncertain methods comparable to horse and buggy transportation to more sure, diversified, and speedier methods of arriving at desired goals. How to achieve this change within communities should concern all public health agencies, including the voluntary agencies, which in many communities have carried the health education burden.

The authors of this report believe that health education to be most effective must contain three elements. It must be brought close to where low-income people live. It must be identifiable. The consumer and the dispenser must stand on a common ground—an aspect which has been particularly stressed by Robert O. Carlson and by Henry Makover.[2] The Visting Nurse Association embodies these three principles: its members visit families in their homes: they are easily identifiable by their uniforms; and they provide services when they are most needed. As a result, the Visiting Nurse Association is the best known of the seven voluntary health agencies considered in the study.

Official and nonofficial health agencies could do a better job of health education if they would veer toward these principles. They might do this in a variety of ways. One is to consider whether the professionally trained health educator can be relied upon entirely to reach all types of families in a low-income neighborhood or block. Just as practical nurses have been found useful in hospitals, so what may be needed are practical health educators who come from the same environment as the families being served, who talk their language, who are well-acquainted with their indigenous leaders, and who can thus better communicate with them and motivate them toward better health habits. Such persons would of course have to work under the guidance of professionally trained supervision. Another method for spreading health information might be to send "roving" health educators into neighborhoods to work in a way similar to the "detached workers" in anti-juvenile delinquency programs. They could carry health information into barber shops, pool halls, beauty parlors, or small independent churches.

All public health agencies need to show a great deal more imagination today in getting their message across to the public that needs it most.

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[1] Cornely, Paul B.; Bigman, Stanley K.: Cultural considerations in changing health attitudes. Department of Preventive Medicine and Public Health, Howard University, December 1961. Research Grant (5357 C1, C2) from the National Institutes of Health, Public Health Service, Department of Health, Education, and Welfare.

[2] U.S. Department of Health, Education, and Welfare, Public Health Service: Web of mutual anticipations; report of the 1960 Eastern States Health Education Conference. *Public Health Reports,* October 1960.

> I try to imagine, sometimes, how painful it must be for a parent to have to tell his young son (and it has to be told by the time he is four or five) that he will automatically be considered undesirable . . . It must be hard to reconcile this, for him, with the religious and ethical ideals you are trying to teach—about God's justice, the good intentions of most people . . .
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> *"Do Parents Teach Prejudice?" Benjamin Spock, M.D., in the* Ladies' Home Journal, *January 1962.*

Highlights from the report of the President's Panel on Mental Retardation . . .

A PROPOSED PROGRAM TO COMBAT MENTAL RETARDATION

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ON OCTOBER 16, 1962, a distinguished group of experts presented a report to President Kennedy on the problem of mental retardation in this Nation. The document, entitled "A Proposed Program for National Action To Combat Mental Retardation,"* was presented to the President by Leonard W. Mayo, chairman of the group. It represented a year of intensive study, conferences, and public hearings by a panel of 28 outstanding physicians, scientists, educators, lawyers, psychologists, social scientists, and citizens concerned with mental retardation. They had been called together a year before at the White House and asked to make a broad study of the scope and dimensions of the various factors that are relevant to mental retardation and to explore ways to prevent and deal with this problem. The panel was specifically asked to make recommendations with regard to:

1. The personnel necessary to develop and apply the new knowledge.
2. The major areas of concern that offer the most hope.
3. The present programs of treatment, education, and rehabilitation.
4. The relationships between the Federal Government, the States, and private resources in efforts to eliminate mental retardation.

The panel's report includes over 90 recommendations. It presents the problem of mental retardation as a major national health, social, and economic problem, affecting some 5.4 million children and adults and involving some 15 to 20 million family members in this country. It estimates cost of care for those affected at approximately $550 million a year, plus a loss to the Nation of several billion dollars of economic output because of the underachievement, underproduction, or complete dependence of the mentally retarded.

The program of action proposed by the panel derives from conclusions arrived at on the basis of its study. Numerous facts are presented to document its statement that: "Mental retardation is a complex phenomenon stemming from multiple causes;" and to show that many of the specific causes are known and can be prevented or their results treated.

Equally well documented is the conclusion that for the bulk of mental retardation cases, a specific cause cannot yet be ascribed. Nevertheless, as the report points out, epidemiological data from many reliable studies show a remarkably heavy correlation between the incidence of mental retardation, particularly in its milder manifestations, and the adverse social, economic, and cultural status of groups of our population. This is especially true for low-income groups who live in slums where the mother and the children receive inadequate medical care, where family breakdown is common, and where individuals lack opportunity and adequate education. In short, the conditions which spawn many other health and social problems are to a large extent the same as those which generate mental retardation. Therefore, the panel has concluded that "to be successful in preventing mental retardation on a large scale, a broad attack on the fundamental adverse conditions will be necessary."

A Broad Attack

From these basic conclusions the panel has recommended a "broad spectrum" attack on many fronts to focus not only on the specific causes of mental retardation but also on the root problems in the social, economic, and cultural environment which nourish the specific causes and seem to have a direct causative influence of their own.

Fundamentally, the panel's recommendations call for the allocation of more resources for services to help the youth of the land achieve health, education, and training, for community reconstruction and renewal, and for improved employment and social services—with special attention to improving opportunities and services for distressed groups in the population. The panel warns that its recommendations will be costly to implement.

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*U.S. Department of Health, Education, and Welfare, The President's Panel on Mental Retardation: A proposed program for national action to combat mental retardation; a report to the President. October 1962. Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. 1963. Price as yet undetermined.

The major recommendations of the panel are grouped into eight categories. While it is impossible to comment on all of these here, presenting a few from each category may indicate the breadth of the report, a little of its detail, and some of its flavor.

Research. The panel has made 19 recommendations concerning research into the causes of retardation and into effective methods of care, rehabilitation, and learning. These include recommendations for developing research centers on mental retardation at strategically located universities and at institutions for the retarded, and for a Federal program of collection and analysis of statistics on the incidence, prevalence, and socioeconomic characteristics of the mentally retarded.

In view of the importance of basic research on learning to the achievement of national goals as well as to the special needs of the mentally retarded, the panel has proposed the establishment by the Federal Government of a national research institute of learning to include an intramural as well as an extramural program.

Prevention. The section on prevention contains 11 specific recommendations, all of which are far reaching in their impact. Major stress in the report is given to the recommendation for a greatly strengthened program of maternal and infant care. This is to be directed first at the centers of population where prematurity, which is closely associated with retardation, and the rate of "damaged" children are high. Protective measures against such known hazards to pregnancy as radiation and harmful drugs are recommended, as is the development of genetic counseling services. The report also recommends that communities undertake long-range programs to improve social, economic, educational, and health opportunities in the slums as well as specific measures to offset the adverse effects of deprivation of intellectual stimulation on the children and youth living in such areas. Among the latter are suggested increases in public health nursing and social casework services to deprived families, day-care centers, guidance and employment services in the schools, parent education services, and homemaker services.

The panel has estimated that the full application of existing knowledge in taking action on a broad front to correct adverse community conditions, as well as in taking more specific preventive measures, would prevent perhaps half of all new cases of mental retardation. Moreover, the panel points out, such action would also reduce the incidence of other health and social disabilities.

Clinical and Social Services. The panel's approach to the subject of clinical and social services is based on the assumption that the richer and the more easily available all general services become, the less need there will be for special services for the retarded. Viewing retarded persons as part of, rather than apart from, the general population, the report calls for the removal of all barriers blocking their access to such general services. It points out, however, that the various services that should be available in this array must be marshaled in different ways and in different combinations for different people in accordance with their needs at different times.

To implement these basic tenets, the panel's recommendations range from providing continuous child health supervision for all children to the extension and improvement of clinical services for the mentally retarded. Additional Federal funds are recommended for the crippled children's program so that physically handicapped children who are also mentally retarded can be served more fully by this program. A "fixed point" of referral and information to which parents and professionals in every community can turn for help is suggested as essential.

The concept of the "continuum of care" which the report spells out in this section merits careful study and consideration. As used by the panel, "continuum of care" involves the selection, blending, and use, in proper sequence and relationship, of the medical, educational, and social services required by a retarded person to minimize his disability at every point in his life span. Thus, "care" is used in its broadest sense, and "continuum" underscores the many transitions and liaisons within and among various services and professions through which the community attempts to secure for the retarded the kind of help he requires. A "continuum of care" permits fluidity of movement of the individual from one type of service to another while a sharp focus is maintained on his unique requirements. The ongoing process of assuring that an individual receives the services he needs when he needs them and in the amount and variety he requires is the essence of planning and coordination.

Education and Training. The section of the report dealing with education, vocational rehabilitation, and training is based on the premise that both public and private school systems have an obligation to provide appropriate educational opportunities for *all* mentally retarded children who can profit from training. The panel points to the need for 55,000 more teachers trained to work with the retarded; calls for the improvement of special education programs, and suggests that centers for instructional material be developed. Other recommendations call for increased State vocational rehabilitation appropriations, the strengthening of school counseling services, the establishment of educational diagnosis and evaluation services, sheltered work opportunities beyond the traditional workshop setting, and recreational activity centers for severely handicapped adults.

Residential Care. The challenge which the panel presents to the Nation in the section on residential care is how to accelerate the change from large isolated facilities to smaller units close to the homes of patients and to the health, education, and social resources of the community. To help residential facilities achieve this pattern, the panel recommends Federal grants to State institutions for support of demonstration projects in the areas of rehabilitation and care, inservice training and education of personnel, and research.

The panel also presents objectives which the administrative authorities of residential facilities can implement. These concern such areas as admission and release policies, treatment goals, diagnosis and evaluation prior to admission, and extension of services beyond the campus.

Perhaps one of the more important recommendations in regard to residential care is that calling on the States to redirect funds earmarked for expanding large institutional facilities to developing the type of facilities there are in some European countries. These include a wide range of diversified residential arrangements in local communities—small units designed in program and structure to meet the needs of specific groups such as infants, the senile, or young adults.

The Law. A refreshingly new legal concept of the retarded is presented in the section on the law. The approach is based on the assumption that "the richer and better the services concerned with their welfare, the less need there is of coercive intervention to provide care." Says the report: "Indeed in dealing with problems that arise with the retarded in the community, formal legal intervention should be regarded as a residual resource and should not occur where social or personal interests can be adequately served without it."

The panel calls for a differentiation between guardianship of the property of a retarded person and guardianship of the person. The development of a limited guardianship of the person is called for, together with periodic review by the courts of the need for continuation of any form of guardianship. Judicial review, every 2 years, of the need for continued institutional care for all retarded adults is recommended. The panel also calls for new approaches in the treatment of mentally retarded criminal defendants.

Organization of Services. The recommendations in regard to the organization of services underscore the panel's basic finding that the problems of the mentally retarded are not and cannot be the responsibility of any one discipline or agency; that rather they must be important concerns of several departments and agencies; that, therefore, they require a multiple, but coordinated, attack. Thus, the report recommends that States set up arrangements such as an interdepartmental committee, a council, or a board to coordinate the efforts of the dispersed services in the community. To encourage the development of such machinery, the panel has recommended that the Secretary of Health, Education, and Welfare be authorized to make grants to the States for comprehensive planning of efforts to combat mental retardation.

Grant-making bodies, both public and private, are urged to give priority to joint enterprises which might provide improved coordination of research, training, and service. Programs of interdisciplinary training are recommended. Models of pilot demonstrations of successful patient management coordinated with training and research are suggested. The section also includes a whole series of recommendations to encourage the U.S. Department of Health, Education, and Welfare to provide greater leadership in stimulating comprehensive planning on Federal, State, and community levels to combat mental retardation.

Public Awareness. The strategic placement at the end of the report of a section on public awareness clearly conveys the panel's feeling that without an expanded program of information and education on mental retardation for the general public and for professional organizations, little progress will be made in implementing any of the recommendations. The panel calls specifically for the use of the mass media of communication to reach a variety of groups with information on different aspects of retardation. The panel again warns in this section that to be effective, none of the agencies concerned can discharge their obligation alone, and recommends that all work in close liaison through a planning and coordinating committee.

Next Steps

On reviewing this report, one may well ask how some of its broad objectives for the retarded differ in kind or degree from desirable goals for other groups with special needs. The panel has answered this by stating that while its recommended objectives for the retarded do not differ fundamentally from what others need, the retarded do not presently receive either the attention or the services accorded to others.

An effective way to achieve results beneficial to many, moreover, is to seize the handle presented by an important segment of the population which has been neglected and lift that group to a higher level without losing sight of the needs of all. If, for example, research in learning is spurred by the urgent and specific needs of the retarded, the chances of gaining information of a generic nature will most certainly be enhanced.

No doubt there will be a great deal of discussion of this report, some in praise and some in criticism. Many people will complain of its unevenness from one section to another in terms of depth. Others will object to the lack of specificity in some of the recommendations. It must be remembered, however, that this report is only one step in achieving the kind of total program which is needed. We have reached this step through a slow beginning of interest in the mentally retarded coupled with a growing dissatisfaction with inadequate salvage efforts. The appointment of a body—the panel—charged with study, review, and the production of a comprehensive report was a tremendous move forward.

The most important step is yet to come. This will no doubt be the most difficult, the longest, and, as Dr. Mayo has indicated, the one with the least amount of glamour. It must consist of a careful examination of the report to determine how the recommendations can be carried out and what this will take. On this phase of activity will hinge the success or failure of the panel's efforts.

The U.S. Department of Health, Education, and Welfare took action in this direction shortly after this report was presented to the President. Through the Departmental Committee on Mental Retardation and in conjunction with the Bureau of the Budget, it analyzed the report in an effort to delineate which of the recommendations involving Federal agencies can be carried out under existing authority, which require new authority, and what would be necessary to implement them. As about half the recommendations relate in some way to responsibilities of the constituent agencies of the Department, or require some type of national stimulation or coordination, such action is a real beginning toward the panel's proposals.

A similar process will need to take place on the part of State and voluntary agencies, private foundations, and religious and professional groups which are involved and concerned. Only through such efforts will the recommendations of the panel eventually be realized.

MATERNAL CARE AND INFANT BEHAVIOR

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DURING the past decade, research on infant development and on environmental determinants of infant behavior has shown tremendous vitality, and the locale of research on these problems has shifted from the clinical couch to the laboratory and the home. Evidence of this renewed vitality and some products of this shift in orientation are found in the volume, "Determinants of Infant Behavior,"* a book based on the discussions of a study group on mother-infant interaction held in London late in 1959 under the auspices of the Tavistock Child Development Research Unit.

The report is impressive evidence of the productive interchange between research workers in clinical and in laboratory settings on several related topics: the adaptation of human mothers and infants during the newborn period; the socialization and development of affectional behavior in mammals; analyses of institutional environments; and the impact of specific environmental factors on the development of social responsiveness. It concludes with a comprehensive theoretical model for research on the development of social behavior, on the formation of attachments to the mother, and on the effects of maternal separation and deprivation during infancy.

Recent critical reviews of the research on maternal deprivation [1-3] have emphasized the limitations of the general concept of deprivation and have suggested the values for both research and practice of a more precise analysis of this undifferentiated concept. Throughout the report of the London discussions, there is emphasis on the analysis of mothering activities in terms of specific kinds and qualities of stimulation. Interwoven with this theme is consideration, with relevant data, of several significant issues: the different effects of the same type of stimulation at different developmental periods; the mother-infant relationship as an interactional system; the significance of the total context—the past learnings and the current situation—in which maternal deprivation or separation occurs.

Mother-Infant Interaction

Studies are reported which emphasize that the mother-neonate relationship is not simply a one-way action, but is truly an interaction. On the basis of detailed analyses of mothers and infants in interaction, Blauvelt and McKenna from the New York State College of Medicine show how the newborn infant responds to the mother's stimulation with activities which orient him to the mother, and how in turn these activities stimulate the mother and furnish her with cues that influence her behavior. If the mother is sensitive and capable of responding appropriately to the infant's cues, a satisfactory relationship is likely to be developed. Otherwise a disturbed relationship may be initiated.

The studies of Gunther of Great Britain and Prechtl of the Netherlands suggest that not all disturbances in early relationships are based on emotional difficulties in the mother, but that physical deviations in both mother and infant may sometimes play a role in initiating disturbed interactions. Gunther, an obstetrician, suggests that disturbances in the adaptation of mother and infant in the nursing situation may often be related to the physical characteristics of the mother's breast. Prechtl, a zoologist, speculates that mild neurological abnormalities in the infant may hinder satisfactory adaptation of the infant and mother to each other.

While these studies emphasize the importance of the very earliest period of life, they tend to deemphasize the significance of a single event as a source of permanent damage. They suggest that although the earliest adaptations of infant and mother may initiate patterns which may be destructive, if maintained, a constructive relationship might be developed if the disturbed pattern is interrupted.

Effects of Separation

Several studies reported in the volume reinforce the conviction that the effects of maternal separation and deprivation are not determined simply, but are modified by the complex interaction of many variables. The outcomes—the severity and types of disturbances—

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*Foss, B. M. (ed.): Determinants of infant behavior. John Wiley & Sons, New York. 1962. 307 pp. $6.75.

are found to differ with varying combinations of factors.

In an experiment designed to study the impact of social deprivation at different periods during the first 2 months of life, Rosenblatt, Turkewitz, and Schneirla, comparative psychologists at the American Museum of Natural History, compared the suckling behavior and maternal adjustment of two groups of kittens, one of which was separated from the mother, and the other not. Their findings point to the significance of such variables as developmental stage at the time of separation, and experiences prior to the separation.

The disturbed behavior of the separated kittens on their return to their mothers seemed to be due mainly to difficulties in dealing with new elements in the nursing situation. Moreover, the adjustment problems of the kittens were not solely based on their own inability to adapt to a changed situation, but to the mother's inability to adapt to their changed needs—a factor which has not been given much consideration in studying the adjustment of separated infants. Clearly this implies the need for a closer look at the therapeutic possibilities in manipulating post-separation environments—maternal attitudes—for infants and young children.

On the basis of their findings, Rosenblatt and associates suggest some modifications in the concept of critical periods for separation. Every age, they indicate, may be a critical period, depending on the individual, for a particular kind of experience of deprivation or trauma will have a different impact on each individual according to the state of the organism at the time, its previous learning experiences, and the conditions in the situation to which the organism has to adjust.

Harlow, of the University of Wisconsin adds to his reports on his well-known studies of infant monkeys raised with cloth or wire mother-surrogates, here presenting evidence that particular kinds of stimulation may be important at one developmental stage and less significant at another. While his earlier data suggested the importance of tactile stimulation—contact-comfort—during early infancy, in the research reported in this volume, he found that tactile stimulation was less significant at a later developmental period. Monkeys introduced to the cloth-mother surrogates after 250 days, or later in infancy than the newborn monkeys of his earlier studies, failed to develop the same strong attachment to their mother substitutes. Harlow, also found that nursing was important in developing the monkey's attachment to the mother during the very earliest part of infancy, but not of great significance at a later period.

Babies in Institutions

Studies of infants in institutions, by Rheingold of the National Institute of Mental Health and by David and Appell in Paris, emphasize the usefulness of analyzing institutional environments in terms of simple dimensions—the amount and variety of stimulation, the consistency of mother figures, the amount and quality of social stimulation, and the learning conditions such as whether the infant's responses are reinforced by appropriate responses.

David and Appell instituted an experiment in which one group of infants was provided with intensive individualized nursing care, each by a single nurse, while the other group was continued on routine care. The results had not been analyzed at the time of the conference, but many interesting impressions were reported. They suggest that in institutions with multiple mothers, there is not sufficient opportunity for one nurse to become sensitized to the individualized characteristics and needs of any one infant. The limited amount of time per contact results in a reduced variety of stimulation, and stimuli "happen at random" rather than in response to the child. Consequently, the learning which occurs in normal situations in the home, stimulated by the reinforcement of desirable responses and the lack of reinforcement of undesirable responses, is less likely to take place in institutional environments.

Although under the experimental conditions the nurses provided more stimulation and more consistent care, the investigators observed that the quality of emotional interchange remained fairly limited. They suggest that this may have been the result of a protective defense on the part of the adults to avoid the hurt of separation.

An interesting question provoked by this study is to what extent very young infants are sensitive to the emotional qualities of the caretaker. Perhaps the depth of emotional interchange becomes important at a later developmental period. Perhaps the amount during early infancy, the variety, and the sensory avenues of stimulation are more significant.

Rheingold, in a careful comparison of home and institutional environments, found marked differences in the amount and kinds of stimulation provided for young infants. Even in a good institution, infants received considerably less stimulation, had significantly less contact with mother figures than infants in homes of high socioeconomic status. Whereas the home infants received almost all their care from their mothers, the care of institutional infants was given during the same time interval by an average of five different caretakers.

If the location of the infant in his environment is used as a measure of variety of stimulation, it is clear that home infants are exposed to more varied stimulation. They are out of their rooms and out of their cribs more of the time and are held more frequently. Rheingold speculated, however, in regard to institutional infants that the "different caretakers, with their different appearances, voices, and manners of administering care, must provide a kind of stimulation the home infant would lack in the usual routine of his day." Therefore, she compared the social and exploratory behavior of 3-month-old infants in their own homes and in institutions.

Surprisingly, she found no significant differences in exploratory behavior between the two groups. Therefore, she suggests that perhaps given a certain amount of stimulation, the quantity and kind of experiences provided by the environment may be irrelevant for the development of exploratory behavior. She also made the surprising finding that the institutional infants showed a greater degree of social responsiveness to the examiner. They smiled more quickly and more often, they vocalized more often, and reached out more frequently for social contact—differences she suggests may be related to the fact that the home children were more discriminating in their responses to strangers and familiar persons.

Gewirtz of the National Institute of Mental Health presents a number of hypotheses regarding the role of specific variables of maternal care in the development of the infant's attachment to the mother, and of his social and emotional responses. Pointing out that the qualities of maternal care, such as love, can only be dispensed as physical stimuli—visual and sound patterns, skin contact, and so forth—he suggests that there has been an overemphasis on "the simple fact of giving a commodity like food or love, and insufficient attention given to the conditions under which stimuli are provided," especially how they are related to the child's behavior. The randomness of stimulation in the institutional environment described by David and Appell could hardly provide conditions for learning socially approved responses.

For too long, authoritative opinions about maternal care and the influence of early environment on personality development have been based mainly on faith and a distillation of practical wisdom. The new look in research on infancy, exemplified in the studies reported in this volume, gives promise of contributing significant new knowledge and providing more substantial bases for services for infants and children. One regrets, however, that in its concentration on analysis of the environment, the conference neglected the constitutional determinants of infant behavior. The many implications of the studies reported in this volume are not immediately apparent. Perhaps most important is the stimulus they provide to look from fresh perspective at child-rearing practices in early infancy, and at service programs for infants and young children who are deprived of normal family life.

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[1] Ainsworth, Mary D.: The effects of maternal deprivation: a review of findings and controversy in the context of research strategy. *In* Deprivation of maternal care—a reassessment of its effects. WHO Public Health Paper No. 14. World Health Organization, Geneva. 1962.

[2] Yarrow, Leon J.: Maternal deprivation: toward an empirical and conceptual re-evaluation. *Psychological Bulletin*, November 1961.

[3] Casler, Lawrence: Maternal deprivation: a critical review of the literature. *Monographs of the Society for Research in Child Development*, Vol. 26, No. 2, Serial No. 80, 1961.

Guides and Reports

MEETING THE CHILDBEARING NEEDS OF FAMILIES IN A CHANGING WORLD: report of a work conference sponsored by the Maternity Center Association, New York. The Association, 48 East 92d Street, New York 28. 1962. 115 pp. $1.

The findings and recommendations of a group of 70 conferees concerned professionally with maternity care who met on March 2 and 3, 1961, to consider how maternity care can be redesigned to achieve health for each family, in the broad terms of physical, emotional, and social well-being.

NEW DIMENSIONS IN INTERGROUP RELATIONS; implications for social welfare. Intergroup Relations Committee. National Social Welfare Assembly, 345 East 46th Street, New York 17. 1962. 26 pp. 40 cents; quantity discounts on 25 copies or more.

A digest of the material presented in a seminar series sponsored by the Intergroup Relations Committee of the National Social Welfare Assembly during 1960–61, with excerpts from the major papers to highlight the chief areas of discussion: the function of a social agency in relation to allaying prejudice; current trends in intergroup relations: the effects of agency structure on its philosophy and services in relation to minority groups; the responsibility of the individual professional worker; lay leadership in both majority and minority groups.

RESEARCH AND POTENTIAL APPLICATION OF RESEARCH IN PROBATION, PAROLE, AND DELINQUENCY PREDICTION: report of a conference sponsored by the Citizens' Committee for Children of New York, Inc., and the Research Center, New York School of Social Work, Columbia University. New York. 1961. 80 pp. Free from the center.

Reporting on an October 1960 conference, the publication begins with a summary of the proceedings, focusing largely on the application of prediction research, and including papers on the use of prediction in evaluating treatment, on studying interactions between kinds of treatment, and on parole followup studies.

GUIDELINES AND OPPORTUNITIES FOR LEADERSHIP IN THE EDUCATION OF GIFTED CHILDREN AND YOUTH. Council of Chief State School Officers, 1201 16th Street NW., Washington 6, D.C. 1962. 28 pp. Single copies available from the council, 35 cents; 10–99 copies, 30 cents; 100 or more, 25 cents.

A guide for helping State departments of education to assist school personnel in identifying individuals with superior potential and in establishing, improving, and appraising educational programs for gifted children and youth.

TULANE STUDIES IN SOCIAL WELFARE: the significance of health and handicaps in the child's growth and development. School of Social Work, Tulane University, New Orleans, La. 1961. 125 pp. Free on request.

A report of the proceedings of the 10th workshop designed to train medical social workers in the public health field in the South and Southwest, sponsored by the Medical Social Work Training Project, a joint undertaking of the Tulane University School of Social Work and the Louisiana State Board of Health. The project is financed by the Children's Bureau.

BOOK NOTES

HUMAN DEVELOPMENT: FROM BIRTH THROUGH ADOLESCENCE. Ira J. Gordon. Harper & Bros., New York. 1962. 400 pp. $5.75.

Designed primarily as a text for university courses in child and adolescent development, this book draws together research and theory from various branches of psychology. Anthropological and sociological material is also integrated into the author's basic approach to the child as an individual whose self-development is fundamentally a transactional process between his growing organism and a changing social environment. The author's underlying philosophy is linked to the theories of such psychologists as Rogers, Lewin and Snygg, and Combs. Dr. Gordon, himself, is on the faculty of the University of Florida.

Major topics of discussion include the following: biological bases for development; the family setting; school, community, and peer group cultures; and the emergence of the self in the individual's quest for identity.

JUSTICE FOR THE CHILD: the juvenile court in transition. Edited by Margaret Kenney Rosenheim. The Free Press of Glencoe, New York. 1962. 240 pp. $6.95.

Do juvenile courts deprive children of some of their constitutional rights by departing from the traditional adversary system? Are current gaps in the practices of these courts threatening the whole juvenile court movement? These are among the issues illuminated in this collective assay—by 10 contributors—of the functions, philosophy, practices, and future of these "agencies of last resort."

Written by judges, lawyers, sociologists, and social workers, under the auspices of the School of Social Service Administration of the University of Chicago, the essays progress from an historical introduction, through an appraisal of "promises vs. performance" by the juvenile courts, some disposition dilemmas, and questions of court administration. They also weigh, in addition to other issues, obligations to the community, especially in regard to accountability. Underscored throughout is the need for defining and guaranteeing the existence of just procedures for judicial intervention in the lives of children.

AMERICAN YOUTH CULTURE: group life in teenage society. Ernest A. Smith. The Free Press of Glencoe, New York. 1962. 264 pp. $5.

Synthesizing and projecting the findings from a broad variety of studies on youth, the author defines the contours of an autonomous youth culture—"a sequence of informal groups and institutions guiding the growth of youth from childhood to adulthood." An assistant professor of sociology and anthropology at Hunter College, the author traces the youth culture's distinguishing characteristics, such as solidarity, concealment of behavior from other age groups, intimacy and informality in intragroup relations, and mass conformity; and finds two basic variables: social class and sex.

The book's 12 chapters, besides analyzing the culture's structure and its socializing function, turn successively to the role of the family, the gang and the clique, the adult norms, dating, courtship, and marriage, considering their dysfunction as well as function within the youth culture.

HEAL THE HURT CHILD. Hertha Riese, M.D. Foreword by Nathan W. Ackerman. The University of Chicago Press, Chicago 37. 1962. 615 pp. $10.

The "hand-me-down of sickness and destitution," the lot of the extremely deprived child, unfolds against a panorama of the misery of the whole way of life of the destitute Negro family in this book about the psychotherapeutic techniques used in the Educational Therapy Center of Richmond, Va. The center's patients are disturbed and neglected children—referred by official and private agencies and sometimes coming for service of their own accord.

Most of the children are severely deprived Negro children, many of whom have had a prior diagnosis of "untreatable," according to the author, the center's psychiatric director. In an introductory chapter, she describes the founding of the center in 1943, in response to the need for a therapy program to salvage children whose "hurts" cannot be healed by the standard techniques of guidance clinics designed for those with some means who reach out for help and whose parents can cooperate consistently. The Center's program she outlines as a combination of psychiatric treatment through individual and group therapy, day care with academic education, foster home placement during treatment, and social work with parents.

Throughout the book's three sections—on the background and symptoms of the hurt child, the child under observation, and principles of therapy—the author presents a long repertoire of child patients, each appearing briefly to illustrate a point, to show the child's adjustment or maladjustment to demands of his subculture and sometimes interaction with the therapist during treatment toward stages of recovery.

READINGS IN THE PSYCHOLOGY OF HUMAN GROWTH AND DEVELOPMENT. Warren R. Baller. Holt, Rinehart & Winston, New York. 1962. 689 pp. $4.75.

A collection of readings from 48 books and other published material, this work was designed primarily as a companion piece to a textbook for student teachers, "The Psychology of Human Growth and Development," by the author and Don C. Charles (See CHILDREN, January–February 1962, p. 29.) Its 15 chapters are grouped into focal areas which orient the student to the study of human behavior and development; examine the biosocial foundations of human behavior; scan the processes of human development and adjustment; and discuss personality and the school's role in its development. The final chapter confronts the question of how a teacher can effectively apply his knowledge of human growth and development to the teaching experience.

Introductory readings are presented at the head of each chapter.

HERE AND THERE

Child Welfare

In November, seven grants totaling $177,887 to carry out research and demonstration in child welfare were awarded by the Children's Bureau to voluntary and public agencies in New York and Chicago. The awards constitute the second group made under the Child Welfare Research and Demonstration Grants Program launched in 1961 (see CHILDREN, July–August 1962, page 165) to find new methods or facilities which show promise of substantial contribution to child welfare.

Among the projects in the new group are demonstrations of homemaker service in a family with a mentally retarded child under 5 years of age; the factors which make it possible to serve both handicapped and nonhandicapped children in community recreation groups; and ways of incorporating vocational planning in treatment programs for disturbed adolescents. Others include research into: the criteria used in evaluating the potentials of adoptive couples; the reasons behind the decline in applications for adoption; ways to curb the flow of children into foster care; and the gaps in knowledge about child welfare practice.

Awards under this grant program are made twice yearly. Awards on applications made before the first of this year are expected to be announced in March, and on those received between January 1 and August 15, in November.

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To provide psychotherapeutic training for social workers in family and children's agencies, child guidance clinics, children's institutions, and schools, the Chicago Institute for Psychoanalysis last October initiated a 4-year program for social workers in the diagnosis and treatment of children with severe emotional disturbances. The first class has 11 social workers from 10 agencies. It meets 2 half days a week.

In addition to producing social worker-psychotherapists for children, the project has the long-range goal of developing a structured, progressive training program as a model for training programs elsewhere in the Nation. The curriculum encompasses the observation of normal development in children; the diagnosis of psychopathology in the child and his family; the unconscious aspects of mental functioning; methods of treating various childhood disorders; functional integration of theory and techniques in child psychotherapy; and the value and proper use of psychiatric consultation. Plans call for recruiting classes every 2 years.

The program is made possible by grants from the Chicago Community Trust, the National Institute of Mental Health, and scholarship funds from the Illinois Department of Mental Health. Ner Littner, M.D., is its medical director; Esther Schour, its administrative director.

WHC Followup

About 1,300 people, representing 63 of the State's 67 counties, participated in the 1962 Pennsylvania Governor's Conference on Children and Youth held in 5 regional sessions last September. Ten percent were youth. Others included judges, probation officers, policemen, teachers, counselors, school principals and superintendents, college deans, county commissioners, employment service personnel, public assistance and child welfare workers, and board members and staffs of councils of social agencies.

Seventy-three State organizations worked with regional planning committees in preparation for the conference. The programs, each geared to regional interests, considered youth employment and training, youth opportunities councils, school and community relationships, juvenile delinquency, family responsibility, child welfare problems, and the development of youth forums. The conference was made the occasion of the release of "A Digest of New Directions for Public Child Welfare in Pennsylvania," a study of Pennsylvania's child welfare programs conducted by the Government Consulting Service of the University of Pennsylvania for the Pennsylvania State Department of Public Welfare. Pennsylvania has carried out more than half of the recommendations made in its State report for the 1960 White House Conference on Children and Youth.

The regional conferences last fall undertook a reassessment of the remaining recommendations in the light of current developments, with the purpose of stimulating enthusiasm for cooperative action programs in local communities.

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The National Committee for Children and Youth on September 13, 1961, formulated an ad hoc committee on the problems of youth of American Indian heritage. This committee of 40 members represents Federal Government agencies working with Indians, State directors in the field of Indian education, private agencies working with Indians, religious leaders, congressional leaders and their legislative staffs, industrial leaders, the editor of an Indian publication, and representatives of various Indian tribes.

The committee is the result of a recommendation of the 1960 White House Conference on Children and Youth that the problems of Indian youth be explored. Its goal is to find ways of drawing nationwide attention to these problems and ways of meeting them.

At its first meeting last fall the committee decided to prepare a directory which could be used by agencies and young Indians as a guide to available resources. The directory will contain summaries of public and voluntary programs serving Indian youth at the community, State, and Federal levels; a section on scholarships available to Indian youth; and a bibliography of pertinent articles, monographs, books, and films. A subcommittee of seven persons is planning the outline for the directory.

Juvenile Delinquency

In 1961, for the first time in 13 years, the number of juvenile delinquency cases coming before juvenile courts in the Nation as a whole dropped slightly—by one percent—below the year before, according to Children's Bureau statistics. (The child population for 1961 was 3 percent higher than in 1960.)

In urban juvenile courts, however,

there was a 2-percent rise in the number of cases. This increase was offset by a 4-percent fall in cases before such courts in semiurban areas, and an 18-percent drop in rural courts, producing the slight decrease for the country as a whole.

In 1960 the overall figure for juvenile delinquency cases had increased by 6 percent over 1959 while the child population rose only 2 percent.

The Federal Bureau of Investigation's Uniform Crime Reports showed a 4½-percent increase in arrests of juveniles by city police and a 2½-percent increase in juvenile arrests by rural police in 1961. In other years, the trend data on reported arrests and on reported court cases had followed parallel lines.

Findings of a survey by the Children's Bureau of more than a score of juvenile courts in the Nation's largest cities during the last quarter of 1961 showed that boys accounted for four out of five of the court cases. Nearly half of their offenses involved property—larceny, unauthorized use of automobiles, vandalism, robbery, or burglary. Half of the girls were apprehended for running away, truancy, or being ungovernable—offenses recorded for less than a fifth of the boys.

Offenses against public order and decency, including such offenses as carrying weapons, using narcotics, being drunk or disorderly, accounted for 10 percent of the cases for boys, and 7 percent of the girls' cases.

CHILDREN'S DEATHS IN REFRIGERATORS

Year	Number of accidents	Number of children		
		Boys	Girls	Total
1950	3	5	2	7
1951	9	10	2	12
1952	10	9	5	14
1953	18	25	5	30
1954	7	6	5	11
1955	11	15	3	18
1956	8	8	3	11
1957	8	5	9	14
1958	11	10	7	17
1959	10	13	2	15
1960	4	4	2	6
1961	16	20	5	25
1962 (11 months)	23	24	11	35
Total	138	154	61	215

More children died in refrigerators in 1962 than in any previous year—as many as 35 such deaths were recorded by December 1, surpassing 1953's all-time high of 30—according to these statistics, which were compiled by the Refrigeration Service Engineers Society, an organization that has been gathering statistics on such deaths since 1946. From 1946 to 1950, only 22 such deaths were recorded. Most of the children who have died in this manner have been between the ages of 3 and 6. Boys have greatly outnumbered girls among the victims. The society's purpose in tabulating such statistics is to educate the public on the refrigerator entrapment hazard and to promote the removal of doors, hinges, and locks on abandoned or unused refrigerators.

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Last autumn, grants were awarded to four cities for planning demonstrations of a broad community attack on juvenile delinquency under the Juvenile Delinquency and Youth Offenses Control Act of 1961.

A grant of $134,012 went to the St. Louis Department of Welfare to develop a program which will be integrated with other Federal, State, and local efforts to improve services in a high delinquency area of the center of the city. (See CHILDREN, May–June 1962, page 242, "Services in Housing.") The Mayor's Commission for Youth in Syracuse received a grant of $141,284 for designing a program in which the United Community Chest and Council and the Youth Development Center of Syracuse University will cooperate; and the Charleston (W. Va.) Youth Community, Inc., a nonprofit corporation of public and voluntary agencies, received a grant of $131,091 for a plan involving the surveying of the entire Kanawha County to determine the forces leading to delinquency. Another grant, of $159,400, went to the nonprofit organization Action for Boston Community Development, for planning a program to be coordinated with foundation- and city-supported programs for community improvement and urban renewal.

This group of awards brings the number of grants for the planning phase of demonstration projects to a total of 15.

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The first grant awarded by the President's Committee on Juvenile Delinquency for a program to counter juvenile delinquency among rural youth—$129,579 to the Lane County (Oreg.) Youth Study Board—was announced in mid-September. Authorized under the Juvenile Delinquency and Youth Offenses Control Act of 1961 (see CHILDREN, November–December 1961, page 233), the grant is expected to lead to development of guidelines for other rural areas.

In the initial phase, the Lane County program calls for study of the extent of delinquency in the county's rural and small-city areas; how it differs from the delinquency problem in large cities; and the potential use of public schools as delinquency prevention centers. The next phase will be directed toward developing a community youth program with dovetailed services in education, employment, recreation, law enforcement, and social services.

In announcing the grant, Secretary of Health, Education, and Welfare Anthony J. Celebrezze pointed out that juvenile court cases in rural areas rose from 44,500 in 1955 to 86,000 in 1959, and that farm areas have higher school dropout rates than urban centers, although farm jobs are rapidly becoming more and more scarce.

Radioactivity

A nationwide program to evaluate the radioactive content of human bones by measuring the content of strontium 90 and other radioactive materials in bone samples from deceased persons was initiated last fall by the Public Health Service's Division of Radiological Health. Strontium 90, which comes chiefly from fallout from nuclear explosions, has only been present in measurable amounts in the environment for about 8 years, according to the Service.

The program, which includes evaluation of geographical and individual differences in bone absorption of radioactive elements, is expected to continue for an indefinite period, thus providing a basis for determining whether levels of absorption are rising.

By November, 76 pathologists and coroners—from 46 cities in 23 States—had agreed to supply bone samples for the study.

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"The overall frequency of mutations is always increased by irradiation," according to the "Report of the United Nations Scientific Committee on the Effects of Atomic Radiation," prepared for the 1962 session of the General Assembly and released in early September. (Official Records: 17th Session, Supplement No. 16(A/5216).) The report had been unanimously adopted by the members of the committee, representing 15 nations including the United States and the Soviet Union. It documents 31 pages of discussion and findings on the somatic and hereditary effects of radiation and estimates of risks with 403 pages of "annexes" containing detailed scientific information and bibliographies of research in the field of radiobiology.

Pointing out that experimental evidence thus far has produced no evidence of a "threshold dose" below which mutations do not occur, the report states: "Although individual mutations vary greatly in their effect, there is no doubt that any increase in mutations is harmful."

The report also finds it clearly established that exposure to radiation even in low doses may occasionally give rise to one or another of a wide variety of somatic effects including cancer and leukemia. Embryonic tissues, it points out, are more sensitive to radiation than many adult ones.

Recognizing that mankind has always been exposed to small amounts of radiation from natural sources, the report recommends that "all forms of unnecessary radiation exposure be minimized or avoided entirely." In regard to the medical use of radiation, it maintains that simple and inexpensive modifications of techniques could reduce the genetically significant exposure to radiation without loss of medically important information.

The effects of any increase in radiation exposure on populations may not be fully manifested for several decades in the case of somatic disease, and for many generations in the case of genetic damage, the report states. Stressing the need for further research, it points out that little is known about the frequency with which harmful effects of radiation are likely to occur, particularly at low exposure levels.

Nutrition

The foods readily available in American markets are both nutritious and safe, according to a Food and Drug Administration study, the major findings of which were released in November. The 1½-year study looked for vitamin content and pesticide residues in foods listed by the U.S. Department of Agriculture as representing a typical diet of the average 19-year-old boy, reported to be "the biggest eater in the United States." About a week's supply was purchased every 3 months from chain groceries in the Washington, D.C., area, beginning in May 1961. Starting a year later, similar samples were also collected in Atlanta, Minneapolis, St. Louis, and San Francisco. Foods normally cooked for eating were prepared with the help of the clinic kitchen of the National Institutes of Health, Public Health Service.

The findings showed the levels of Vitamin A, thiamine, riboflavin, and niacin to be more than twice as high as the recommended dietary allowances of the Food and Nutrition Board of the National Research Council. Vitamins B_6 and B_{12} were well above the amounts estimated as required for good nutrition. Vitamins C and D were not studied. It was pointed out by the investigators, however, that other studies have shown them to be adequate in American foods.

Most of the samples contained no residues or mere traces of the 20 chlorinated hydrocarbons, including DDT, for which they were tested; and a few contained amounts measurable only by highly sensitive techniques. A few traces of organic phosphate were found. FDA scientists interpret the findings as an assurance of confidence in the protection afforded by the Pesticide Amendment of the Federal Food, Drug, and Cosmetic Act.

The study's experimental procedures and detailed findings are being prepared for publication by the Food and Drug Administration.

Peace Corps

In a new approach to training its volunteers for community development work in Latin America, the Peace Corps sent 80 trainees, who were slated to serve in 8 cities of Colombia, to New York City in early October for 4 weeks of field work, mainly in Manhattan's Spanish-speaking districts. Organized by the New York School of Social Work of Columbia University, this phase of their training entailed classes in social work and Spanish plus 8 hours a day of community work. The latter included adult education, recreation, and housing rehabilitation—supervised by the city's departments of health and welfare and the neighborhood conservation bureau of the city's Redevelopment Board, with the assistance of 10 voluntary agencies. The group had had 8 weeks of prior training at the University of New Mexico and 4 weeks in Puerto Rico.

In mid-November, the trainees arrived in Colombia to develop self-help projects and assist in setting up programs of adult education, home economics, health education, child care, and recreation.

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During the second week of October, delegates from 43 countries assembled in Puerto Rico for the Peace Corps-sponsored international conference on "Human Skills in the Decade of Development." Several delegates announced that their nations had plans for programs similar to the Peace Corps: West Germany, Denmark, Belgium, and Norway were planning to send volunteers overseas; and Jamaica, Chile, and

Honduras were projecting volunteer programs for domestic service.

The conference set up an interim secretariat for the international exchange of information on volunteer assistance and on-the-job training.

Mental Retardation

A 3-year experimental program in which 50 mentally retarded preschool children were trained and their parents concurrently given psychotherapy had the effect, by the time the program ended in 1961, of reducing distractibility among the children and enhancing emotional maturity among the parents, according to a report released recently by the Institute for Retarded Children of the Shield of David, New York, which conducted the project under the auspices of the National Institute of Mental Health. The sample of children, from intact homes and with retardation of physiological origin, ranged in age at the start of the study from 9 months to 4 years 11 months.

The training was provided by a multidisciplinary team which stressed social adjustment, emotional development, curriculum skills, and speech and language development. For this the children were divided into three groups: those under 3 years of age (14); 3-year-olds (19); and 4-year-olds (17). They were matched by a control group of untrained retarded children.

At the end of the experiment, the general emotional tone was found to be improved among the children in all three of the trained groups, in contrast with those in the control group. Curriculum skills advanced for all except those in the group under 3, who, however, improved in the general conditions, such as alertness, that facilitate training. The 3-year-olds were better than before in articulation, and the 4-year-olds, in receptive, expressive, and articulation areas of speech. In spite of these gains, IQ scores did not change significantly. This fact, in the opinion of the investigators, suggests that intellectual measurements—gauging what the child *cannot* do rather than what he *can* do—may be inadequate predictors of successful academic achievement in special classes and special schools.

The parents, none of whom were severely disturbed or mentally retarded, also improved after therapy, in psychological stability, organizational ability, constructiveness of attitude toward the child, relations with the spouse, and frustration tolerance in daily living. Feelings of hopelessness, depression, anxiety, and guilt were found reduced.

The report, noting an apparent higher incidence of organic difficulties in this group of parents than would be found in a comparable group of parents in general, suggests the need for further study of the physiological status of such parents.

Public Assistance

A nationwide review of eligibility in the Federal-State program of aid to families with dependent children, requested by the Senate Appropriations Committee, is beginning this January and is scheduled to continue for 3 months. A joint undertaking of Federal, State, and local personnel, the review will involve field investigations of 2 percent—or about 21,000 cases—of the entire AFDC caseload. The eligibility of these cases will be checked against both State and Federal laws. A report of the findings will be made in June. The review will involve the 50 States and the District of Columbia, but not Guam, Puerto Rico, or the Virgin Islands.

Under the review plan, devised by the Bureau of Family Services with the help of an advisory panel appointed by the Commissioner of Social Security, two samples will be drawn each month from the 28 States that have more than 10,000 cases each and together account for 90 percent of the total caseloads. Sample A, regarded as a test of the quality of the local agency's eligibility determination, will be selected from cases which have undergone an eligibility determination or redetermination within the last 30 days, and Sample B will be drawn from other active cases on the rolls. In the 22 States with smaller caseloads, samples will be drawn only from cases which have had recent eligibility determinations, as in the "quality control" Sample A. About 450 staff members of State welfare agencies, or local welfare agency workers assigned to the State agencies and working under State supervision, will provide the basic manpower, with Federal staff members from the Bureau of Family Services observing and making spot checks.

In releasing the plan to the press in mid-December, Robert M. Ball, Commissioner of Social Security, announced that the "quality control sampling" of cases is expected to be continued as a regular part of administration. While Federal spot checking of eligibility has been a normal part of the administration since the beginning of the program, this has in the past been carried out on a periodic basis by the review of case records.

Mr. Ball also pointed out that grounds for eligibility vary in the States and often include factors other than need, the degree of which also varies as a criterion for eligibility. For example, in 14 jurisdictions the father must not be present in the home unless he is incapacitated; and in many States long-time residence in the State is required.

Miscellaneous

The Delta Gamma Foundation is offering scholarships for the training of orthoptic technicians and teachers and consultants for visually handicapped children. Deadline for applications is April 1. For further information, write to the Delta Gamma Central Office, 3250 Riverside Drive, Columbus 21, Ohio.

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Beginning next September, the Girl Scouts of the U.S.A. will have four age groups instead of the present three. Members aged 7 and 8 years will be Brownie Girl Scouts; aged 9, 10, and 11 years, Junior Girl Scouts; aged 12, 13, and 14 years, Cadette Girl Scouts; and 15 through 17 years, Senior Girl Scouts. Until then the 2½ million girls in Scouting will continue in the membership structure of Brownie Scouts ages 7 through 9; Intermediate Scouts, 10 through 13; and Senior Scouts, 14 through 17. New handbooks for each level will be issued.

READERS' EXCHANGE

ATKINS et al.: *The time is now*

The article by Drs. Atkins, Rose, and Smith points up a disturbing and indeed inexcusable characteristic of far too many communities in their pattern of services for children. ["Emergency Care of Disturbed Children," by Thomas E. Atkins, John A. Rose, and Ora R. Smith, CHILDREN, November-December 1962.] When a demonstration such as the one these authors describe shows that psychiatric emergencies presented in children reflect "problems of services" as much as they do "the extent and nature of the child's disturbance;" when we have to acknowledge that the acute disturbance in the child is due in large part to ineffective planning on the part of services as well as on the part of the family, then I submit that all of us in social work, whether in the public or voluntary field, must ask ourselves some searching questions.

We can no longer accept the independence of the voluntary child welfare agency, if by independence we mean "going it alone" in the provision of service without acceptance of responsibility for the relation of that service in function and quality to every other service in the community. We cannot narrowly define the area of child welfare services and permit wide gaps in services to children that private philanthropy cannot or will not fill and that government has not been mandated by its citizens to provide the funds to fill. The need for an examination of the network of services for all children in every community is long overdue. One of the goals of such an examination should be assurance that there actually exists a comprehensive, integrated pattern of services under a variety of auspices, each complementing the other, for all children who need them.

The article stimulates me to ask myself how this goal can promptly be realized. More and more I am coming to believe that the planning and coordinating function in child welfare may have to become a governmental function with community sanction to assure that this comprehensive, integrated pattern to which all of us subscribe is established and supported. In such a scheme the full resources of voluntary agencies would be utilized, but there would be the legal mandate to the public planning and coordinating body to establish and support under public auspices those high quality services that are required to close the gaps. Such a body might promulgate standards and establish patterns of relationships to which all social agencies in a community could subscribe.

I disagree with the authors when they say that it is unlikely "that much can be accomplished immediately to change materially the factors contributing to the emergencies." I believe that much can be done *now* if we are willing to re-examine what we want for children and determined to provide it, whatever the cost in money and change in approach to planning and coordination.

I hope the article stimulates some soul-searching in every community as to the importance of our children and their welfare as against the importance of the present approach to planning and coordination in child welfare in too many of our communities.

James R. Dumpson
Commissioner of Welfare, City of New York

Interpretation needed

The problems involved in planning for emotionally disturbed children on an emergency basis as described by Atkins and associates in the November–December 1962 issue of CHILDREN exist to a great extent for all children who require community protection and services.

These problems are intensified by a lack of diversified community resources to meet the special and complex needs of individual children. Too often, our planning for children must be based on the limited resources that exist rather than on the basis of diagnostic findings. When this is so, the resilience of some youngsters may, for a time, help them to achieve a fragile equilibrium, but when this is upset we are confronted with a crisis in which the child's weaknesses are exaggerated and his strengths underestimated. The faulty planning which may ensue may further compound the problem.

With the increase in the number of emotionally disturbed children coming into foster care, this problem has become more severe. Some child care agencies and institutions have responded by strengthening their professional programs and by developing new facilities, such as small group homes. Many agencies, however, do not have sufficient child care staff for this. Nor do they have the intramural school most emotionally disturbed children need because of their defeatist attitude to learning and their intense hostility to teachers.

Child welfare leaders have been timid in interpreting to the community the magnitude of the problem and the substantial cost involved. To illustrate, a committee of juvenile court judges in a midwestern State is currently studying the institutional needs of juvenile delinquents. It has found that the State will have to spend from $45 to $65 million for five different types of facilities to meet present needs and those anticipated by 1970. The annual cost of operation of these facilities is estimated to be $18 to $23 million compared with current expenditures of $6 million. A major job of interpretation will be required to help the community to understand the urgent need for this program.

Child care and treatment facilities alone, however, cannot meet child welfare needs in their broadest and most total sense. It is significant and hopeful that our Federal Government at long last has recognized the importance of building in preventive services for public welfare programs which involve the welfare of millions of children.

Leon H. Richman
Executive Director, Bellefaire, Cleveland, Ohio

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Frontispiece, Esther Bubley

Pages 5 and 7, *The Voice* Publishing Co., Miami, Fla.

SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

EDUCATION FOR FREEDOM AND WORLD UNDERSTANDING; a report of the working committees of the Conference on the Ideals of American Freedom and the International Dimensions of Education, March 26–28, 1962, Washington, D.C. Department of Health, Education, and Welfare, Office of Education. OE–10016. 1962. 62 pp. 30 cents.

Summarizes the deliberations of a conference at which some 140 educators, on invitation of the Office of Education, discussed ways of giving American ideals of freedom more effective expression in education and of creating understanding of our own institutions and the cultures of other peoples.

MENTAL RETARDATION; activities of the U.S. Department of Health, Education, and Welfare. Departmental Committee on Mental Retardation. Department of Health, Education, and Welfare. May 1962. 77 pp. 50 cents.

This report discusses briefly the problem of mental retardation, summarizes the present activities and expenditures of the four agencies within the Department of Health, Education, and Welfare which are primarily responsible for the development and execution of programs concerned with mental retardation, and defines the charge of the President's Panel on Mental Retardation in relation to present and future programs of the Department's agencies. It also includes a list of the Department's publications on mental retardation.

A LIST OF SHORT-TERM JUVENILE PROBLEM INSTITUTES FOR POLICE; AND COLLEGES AND UNIVERSITIES OFFERING TWO AND FOUR YEAR DEGREE PROGRAMS IN POLICING. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1962. 18 pp. Single copies available from the Bureau without charge.

Compiled by the Bureau's police consultants for those interested in developing training programs for police who deal with juveniles, the publication lists institutes ranging in duration from 3 days to 12 weeks and gives content areas: information on faculty, teaching methods and techniques, sources of financial support; and on higher educational institutions, giving degrees offered. Locations and sources of information are noted in each instance.

MANAGEMENT OF NEWBORN SIBLINGS OF PATIENTS WITH PHENYLKETONURIA OR GALACTOSEMIA. George M. Guest, Helen Berry, and Jack R. Rubenstein. 1962. 15 pp.

AN INVENTORY OF CHILDREN WITH PHENYLKETONURIA. 1962. 12 pp. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. Single copies available from the Bureau without charge.

The first of these pamphlets presents recommendations for early detection and treatment of phenylketonuria or galactosemia in newborn siblings of affected parents, along with a summary in tabular form of 18 answers to a questionnaire sent to 23 physicians in medical centers in the United States, Great Britain, Ireland, and Germany regarding the diagnostic procedures and case management.

The second discusses briefly the problem of phenylketonuria and the need for followup study of the effects of dietary treatment on this disease; summarizes the findings of a 5-year inventory, taken from 1957–61, of location, age, and treatment status of children with phenylketonuria; and includes nine tables with pertinent statistical information.

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MARCH • APRIL 1963

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

UNMARRIED PARENTS

what is and is not being done for them and about them

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AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

children ®

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NUMBER 2
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A CHILD IS A CHILD, but much of the quality and richness of his life's relationships may be forged at the start by the circumstances into which he is born. Whether or not his parents are married to each other can have a profound effect on the shape of his future in many spheres, including the scope of his legal rights. The legal status of unmarried parents and their children is discussed in an article beginning on page 55.

◀ *the authors*

Before she joined the Children's Bureau staff in 1960, Hannah Adams (left) was director of data and statistics for the National Board of the YWCA. Previously, she was with the United Community Services of Boston. Ursula M. Gallagher (right) came to the Children's Bureau 7 years ago from the Catholic Social Service in San Francisco, where she was executive assistant.

Rose Bernstein was a member of a team that recently reviewed research and demonstrations concerning births out of wedlock for the Children's Bureau, a report of which is now in process. She has worked with unmarried mothers at the Jewish Board of Guardians in New York and at the Crittenton Hastings House in Boston. She has also worked in child guidance clinics and other social agencies.

After receiving his doctor of law degree from the University of Chicago in 1958, Sanford Katz was for a year law clerk to Marvin Jones, Chief Judge of the U.S. Court of Claims. Since 1959, he has been on the faculty of both the law school and the school of social service of the Catholic University of America. He has written several articles on legal problems in relation to the family.

Social work in schools has been the primary focus of Jerry Kelley's career—as a school social worker in Illinois, where he organized social work departments in two school systems; as assistant director of the National Association of Social Workers, with special responsibility in school social work; and as consultant in school social work to the U.S. Office of Education. He is a graduate of the University of Chicago School of Social Service Administration.

A graduate of the New York School of Social Work, Reuben Pannor was for 2½ years at the Lehigh Valley Child Guidance Clinic in Bethlehem, Pa., before joining the staff of the Vista Del Mar Child-Care Service 10 years ago as a caseworker. In collaboration with his colleagues, he has written extensively for professional journals on services to unmarried parents.

Before assuming her present position this February, Patricia Garland directed staff development in the Bureau of Child Welfare, New York City Department of Welfare. Previously, she worked with unmarried mothers and on adoption at the Louise Wise Services in New York. She is a member of the executive committee of the National Association on Service to Unmarried Parents.

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SOME FACTS AND OBSERVATIONS ABOUT ILLEGITIMACY

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Children's Bureau

BIRTHS out of wedlock are not new to our time. We have only to refer to the Old Testament to realize the concern with which the problem was viewed many centuries ago. True, reactions to this phenomenon have varied in accordance with social and cultural influences, religious principles, and specific traditions and customs in respect to marriage in particular societies. The symposium presented in this issue of CHILDREN is concerned with problems of unmarried mothers in the United States, problems which stem from the social, environmental, and emotional conflicts that are perhaps inevitable in a society that accepts marriage and family as its cornerstone.

The widespread interest in this subject is evident all around us and takes many forms, ranging from genuine concern about alleviating the problem to a punitive sense of outrage. The emotional problems which often lead to unmarried motherhood have been given special attention by psychiatrists [1] and social workers.[2] Cultural and sociological aspects have also received attention.[3-5] More research regarding the whole subject has been recommended, with Elizabeth Herzog pleading that we study questions needing to be answered and question answers that have been too readily accepted.[6]

This symposium does not pretend to give all the answers to this complex problem, nor do the authors pretend to know them all, for, despite the efforts to gain understanding of why unmarried mothers defy the mores of society and how they and their children can best be helped to find a constructive place in society, there are still many unknowns. However, some areas of special concern will be given attention here in the hope of stimulating not only further study of the problem, but action where urgently needed. To do this, it is important to consider what we do and do not know about the extent and nature of the problem.

Extent of the Problem

The most inclusive figures available on the incidence of illegitimacy are birth statistics gathered by the National Vital Statistics Division, Public Health Service, Department of Health, Education, and Welfare. These figures include estimates for 15 States which omit information on legitimacy from birth certificates. They are also incomplete because no births to married women are reported as illegitimate and because of a tendency to conceal the fact of illegitimacy through a falsified birth record or to fail to register a birth out of wedlock at all. Moreover, concealment may more often be successful among mothers of higher socioeconomic status, with the result that white births out of wedlock may be underreported to a greater extent than nonwhite.

The estimate of the total number of births out of wedlock in 1960 is 224,300. Sixty-three percent of the illegitimate births reported in 1960 were to nonwhite mothers and 37 percent were to white mothers. Table I shows the numbers and rates of illegitimate births for selected years between 1945 and 1960. During this period there was a great increase in births over the level of the previous 15 or 20 years. The fertility rate for all women of childbearing age in the United States rose from 86 births per 1,000 women aged 15 to 44 years in 1945 to 120 births per 1,000 women in 1959. During the same period the rate of births out of wedlock per 1,000 unmarried women of the same age group also rose from 10 to 22 per 1,000. This means that the 1½ million more births occurring in 1959 than in 1945 included about 100,000 additional births out of wedlock.

There were 91,700 illegitimate births to teenage girls in 1960 compared with 51,700 in 1945. In 1960, of the 91,700 teenage unmarried mothers, 43,400 had reached the age of 18 years, but 48,300 (a little more than one-fifth of all women who became unmarried mothers in 1960) were girls of school age.

The rate of out-of-wedlock pregnancies was highest for the entire period not among teenagers as many people seem to believe but among women between 20 and 30 years of age. It also has increased the most in this older age group. In fact, among girls from 15 to 19 years of age, the illegitimacy rate showed no increase between 1956 and 1960 but a slight downward trend. At present the annual illegitimacy rate is about 15 per 1,000 among teenagers and about 40 per 1,000 among unmarried women of 20–30 years.

Moreover, the proportion of all unmarried mothers who are teenagers has remained practically the same since 1955 and is even slightly lower than in earlier years. The percentage of all unmarried mothers who were under 20 years of age was 44 percent in 1945 compared with 41 percent in 1960.

Many persons concerned about the extent of illegitimacy believe that most unmarried mothers are receiving public assistance in the Federal-State program of aid to families with dependent children. In a report issued in 1960, the Bureau of Family Services (then the Bureau of Public Assistance), Department of Health, Education, and Welfare, estimated that 2.5 million children in the United States under 18 years of age had been born out of wedlock. Of these, only 13 percent were receiving aid to dependent children in November 1958.[7] A study of births out of wedlock in North Carolina in 1959 showed that the proportion of illegitimate children in the State receiving aid to dependent children was 18 percent.[8] Studies made in other States or communities also refute the misconception that most unmarried mothers are recipients of aid to dependent children.

Reports of the Florence Crittenton Association of America or of The Salvation Army or other agencies serving unmarried parents show that pregnancy out of wedlock does not occur only among the economically and socially deprived, nor only among dull or uneducated women as some persons seem to think. Many high school graduates and college students receive service in social agencies in connection with out-of-wedlock births.

Attitudes toward unmarried mothers range from the extremely punitive to the forgiving. There are those who would include the child in the punishment by withholding public assistance from both mother and child regardless of their need. Others would allow the young girl "one mistake." Too often the idea of helping a person in trouble is confused with condoning what she did.

Any ready answer to the problem of illegitimacy can only arise from a circumscribed view of the factors associated with or contributing to it. Problems related to a marginal standard of living undoubtedly enter in. But to regard social deprivation as the sole cause leaves us without answers as to why the "girl next door" or the woman with substantial means becomes pregnant out of wedlock. Another factor may be found in society's inconsistencies in attitudes toward sex, which are a source of uncertainty and confused values among young people.

We also get a distorted picture of the etiology of illegitimacy if we ignore the influence of conflicts between parent and child, deprivation of love, damaged security, and absence of opportunity to achieve or gain satisfaction in everyday living. Knowledge of personality structure, human behavior, and the dynamics of social functioning must be taken into consideration when examining this whole problem, as well as the problems of any individual unmarried mother. While the theory that cultural attitudes among deprived groups are causative factors may help to explain some illegitimacy, it leaves us without answers as to the causation of illegitimacy among middle-class women. Actually, environmental, social, and emotional factors are frequently interwoven in the causation of out-of-wedlock pregnancy. There is no such thing as a "pat" answer to the problem.

Social and Health Services

Both the complexity of the problem of illegitimacy and the misconceptions concerning the girls and women involved raise questions concerning the adequacy of existing provisions for service to unmarried mothers.

In a recent Children's Bureau study, estimated figures on services to unmarried mothers by public and voluntary child welfare agencies in 1960 were compared with the total number of illegitimate births

Table I

BIRTHS OUT OF WEDLOCK, 1945–60
estimated number and rate

Year	Number			Rate per 1,000 unmarried women 15–44 years
	Total	White	Nonwhite	
1945	117, 400	56, 400	60, 900	10. 1
1950	141, 600	53, 500	88, 100	14. 1
1955	183, 300	64, 200	119, 200	19. 3
1956	193, 500	67, 500	126, 000	20. 2
1957	201, 700	70, 800	130, 900	20. 9
1958	208, 700	74, 600	134, 100	21. 0
1959	220, 600	79, 600	141, 100	22. 1
1960	224, 300	82, 500	141, 800	21. 6

Source: The National Division of Vital Statistics, Public Health Service

reported in 1959. Table II shows this comparison.

About one unmarried mother in six received service from a public or voluntary child welfare agency. The younger mothers were more likely to receive service than the older ones—almost one in three of those under 15 years of age compared with one in seven of those past 20 years of age. For all age groups the number of unmarried mothers who were not reached by child welfare services far exceeded the number who were served, although an unknown number received comparable services from other types of casework agencies.

The fact that a large number of unmarried mothers receive no prenatal care or social services even in a city with many health and welfare agencies is dramatically pointed out in two recent studies in New York City.[3, 9] (See CHILDREN, September–October 1961, pages 184–188.) Both studies showed that about one-half of the unmarried mothers studied did not obtain medical care during the first 6 months of pregnancy, including 15 to 17 percent who had no care up to confinement other than a single visit to a doctor or clinic to confirm the pregnancy. The contrast with the extent of prenatal care among married mothers in New York was marked.

Health hazards to unmarried mothers were documented in one of these studies.[3] It showed that: (1) a higher proportion of out-of-wedlock than in-wedlock births were premature; (2) the death rate for infants born out of wedlock during the 5-year period studied was higher than for infants born in wedlock—48.2 as against 23.9 per 1,000 live births; (3) prematurity and infant mortality were associated with lack of prenatal care—in the same period there were 116 deaths per 1,000 babies born to unmarried mothers who had not had prenatal care and only 32 deaths per 1,000 babies born to unmarried mothers who had had prenatal care.

The other study[9] also showed that 29 percent of the mothers had had no contact with a social agency during pregnancy. Interviews with the women who had not sought out social services indicated that they did not see themselves as needing the things which they thought social agencies were chiefly concerned with providing. They seemed to think that agencies provided tangible things only and did not understand that the services could help them in making decisions about themselves or their babies. A few of the women interviewed who were in serious financial straits had not applied for public assistance because of fear that relatives would learn of their pregnancy, that their children would be taken away, or that support would be sought from the putative father.

Statistics for the year 1961 indicate that about 17,000 unmarried mothers were served by public child welfare agencies and 33,000 by voluntary child welfare agencies (not including maternity homes). The age groups of unmarried mothers served by both types of agencies were similar. Nearly one-half of those served by each group of agencies were 21 years of age and over; roughly one-third were between 18 and 21 years of age; and roughly one-fourth were under 18.

Among the services provided by these agencies were arranging for the unmarried expectant mother's medical care or for her to live in a maternity home or foster home during pregnancy, helping her to continue her education or to find a job, or placement of the babies for adoption.

Some additional information is available on the characteristics of unmarried mothers who are known to public child welfare agencies. On one day in 1961 there were about 6,500 girls and women with the problem of illegitimate pregnancy receiving service through State and local public child welfare programs. Three-fourths of them were white, though only slightly over one-third of all illegitimate births in 1959 were to white mothers.

Fifty percent of these 6,500 unmarried mothers were living with parents or relatives, 16 percent were in independent living arrangements, and 24 percent were in foster care—13 percent in foster homes and 11 percent in maternity homes. One-third were from families receiving public assistance.

While complete figures are unavailable, it is possible to make some estimates of the numbers of unmarried mothers served by maternity homes—agencies designed to provide residential care for illegitmately pregnant girls and women. At present there are in this country approximately 190 maternity homes, located in 46 States and the District of Columbia, having a combined capacity of about 5,000 unmarried mothers. Forty-five are nonsectarian agencies affiliated with the Florence Crittenton Association of America, 35 are operated by The Salvation Army, about 50 are operated under Roman Catholic auspices, and about 60 others are operated by other religious groups or are independent nonsectarian social agencies.

We know from reports made to the Children's Bureau that on one day a few years ago 90 percent of the total capacity of these homes was in use. With full use of the present capacity of 5,000 mothers and an average of 70 days of care per mother, about 25,000 could be cared for in a year. Certainly they do care for well over 20,000 a year—about 1 out of 10 of the 224,300 mothers who had illegitimate children in 1960. Many of the unmarried expectant mothers cared for in maternity homes are the same persons reported as receiving service from child welfare agencies, since these agencies often refer their clients to maternity homes for special care and maternity homes in turn often refer women and girls to child welfare agencies for adoption planning or casework service.

Something about the characteristics of the unmarried mothers who receive maternity home care can be assumed from the 1961 annual reports of the Florence Crittenton Association of America and The Salvation Army. The 80 maternity homes associated with these national agencies have about one-half of the total capacity of all the homes. In 1960 they served 14,400 unmarried mothers—Florence Crittenton homes, 6,500; and Salvation Army homes, 7,900. About three-fourths of these girls relinquished their babies for adoption. The girls were on the whole younger than the unmarried mothers served by child welfare agencies, about 70 percent being under 21 years of age. About a third were under 18.

The proportion of nonwhite mothers among the clientele of these homes was relatively low—12 percent for The Salvation Army and the Florence Crittenton Association combined. In contrast, an estimated 25 percent of the unmarried mothers served by public child welfare agencies are nonwhite, while about 60 percent of all illegitimate births are to nonwhite mothers. If the proportion of clients who are nonwhite is the same in all maternity homes combined this would mean that about one-fourth of all white unmarried mothers reported are served by maternity homes, but only 1 in 50 nonwhite mothers receive such care.

Children Who Are Adopted

Against the total of 224,300 illegitimate births in 1960 can also be measured available statistics on adoption. Since most adopted children are placed in their adoptive home before they are a year old and the adoption is often completed about a year after placement, it seems reasonable to look at figures on adoptions completed in 1961 in relation to illegitimate children born in 1960.

The number of illegitimate children for whom adoption petitions were granted during 1961 is estimated to be 66,100—29 percent of the number of illegitimate children who were born in 1960. While the race of these 66,100 children is not known, we do know that about 90 percent of all children adopted are white. If 59,500 of the out-of-wedlock children who were adopted were white and 6,600 were nonwhite, this would mean that about 70 percent of the 82,500 white babies born out of wedlock, but only about 5 percent of the 141,800 nonwhite babies born out of wedlock, found permanent homes with adoptive parents. Even if all of the 11,400 nonwhite children who were adopted were illegitimate (which is unlikely), they still would amount to less than 10 percent of all nonwhite children born out of wedlock.

Estimates of adoptions of illegitimate children in recent years show an increase in the number adopted, but little change in the ratio to the total number of children born out of wedlock.

Mothers Who Keep Their Babies

Fragmentary as the national figures are on social services provided unmarried mothers, they leave little room for doubt that a majority of all unmarried mothers keep their babies without help from social agencies in working out a plan. Information is missing on many important points—how much education they had, how many were still attending school, their occupational skills and work experience, their degree of emotional maturity, how many lived with parents or had relatives or friends who maintained a supportive relationship with them, the social status of the families from which they came, their own and their families' economic resources. More facts along these lines would give us a better indication than we now have of how many of these mothers needed service they did not receive. Sometimes the service through which a mother receives medical care includes help with social problems from a social worker or public health nurse. Unmarried mothers also receive some social services in relation to the illegitimate pregnancy from public assistance workers or caseworkers in voluntary family service agencies, but we do not know how many nor how much.

The Bureau of Family Services' report referred to on page 44 shows that of an estimated 2.5 million children under 18 in the United States who had been born out of wedlock, 31 percent had been adopted, 13 percent were receiving aid to dependent children, and 1 percent were in foster care.[7] Little is known about the remaining 55 percent. This large group, which included over three-quarters of the nonwhite children and one-fifth of the white children under 18 years of age born out of wedlock, suggests that the majority of unmarried mothers who keep their children continue to manage in some way through subsequent marriage, employment, or support of their children by relatives, friends, or other means, but we know very little about the kinds of homes in which their children are growing up.

We do know, however, from many cases which have come to the attention of social or health agencies or courts that some of these children are brought up by grandparents or other relatives, that some are passed along to strangers who do not want them, that some are eventually brought by their mothers to agencies for placement in foster homes or institutions. Among these last, too frequently are children who bear the emotional scars of deprivation and rejection.

Some Service Needs

On pages 49–54, Rose Bernstein discusses some of the more flagrant gaps in services to unmarried mothers. These gaps are in a sense the *raison d'être* of this issue of CHILDREN. Credit, however, must be given to the efforts of those social agencies which have been working long and hard to serve unmarried mothers and to improve and extend their services—especially to those unmarried mothers who are little more than children themselves.

Table II

SERVICES TO UNMARRIED MOTHERS
by Child Welfare Agencies (public or voluntary)

Age of mother	Total number of births out of wedlock, 1959	Unmarried mothers served by child welfare agencies, 1960 [1]	Percent of total
All ages	220, 600	35, 000	16
Under 15 years	4, 600	1, 400	30
15–17 years	43, 100	7, 400	17
18 and 19 years	41, 500	7, 000	17
20 years and over	131, 600	19, 200	15

[1] Estimate.

Although the rate of births out of wedlock among teenagers has not increased in recent years, services to teenage unmarried mothers are of great importance because of the potential damage of the experience to their whole lives and to the lives of their children. Social services that will help these young girls who are psychologically, socially, and economically unprepared for motherhood to gain more insight into their behavior and to see clearer goals for the future will give them an opportunity to adjust to society's expectations and to develop a more mature sense of responsibility. A hopeful fact about them is that they are apt to be resilient enough to learn from experience.

Followup services for these girls after the birth of their babies are not always available but some social agencies do attempt to provide them with further counseling in regard to boy-girl relationships, adjustment to peers, and understanding of their parents' attitudes and expectations; or with planning for return to school, vocational training, and recreational activities. The earlier in her pregnancy that an unmarried mother receives casework counseling, the more likely she will be able to handle her own problems after plans have been made for the baby. The special problems of enabling young unmarried mothers to continue their schooling are discussed by Jerry Kelley in the article beginning on page 60.

A component of services to minor unmarried mothers is service to their parents, since the attitudes of the parents have a direct bearing on the effectiveness of service to the daughter. How can the parents be helped to assess the factors which may have led to the problem, cope with their possible sense of guilt, and build a constructive relationship with their daughter? These are questions which too often are overlooked.

The unmarried father also is likely to have problems and to be in need of services that will help him acquire a greater knowledge of self and assume a responsible attitude. Reuben Pannor discusses this on pages 65–70. As he points out, helping the unmarried father who is a minor should, whenever possible, involve the provision of service to his parents.

Cooperative Efforts

Over the past decade there has been a movement toward interprofessional efforts to increase understanding of the problems pertaining to births out of wedlock and for help in planning services that are needed. While the initial efforts have been focused on adoptions, a greater awareness of the problems of the child's natural mother and her medical, social, legal, and emotional needs has been gradually evolving. Medical groups have been concerned about both the inadequacy of prenatal care received by unmarried mothers and their need for special counseling by social agencies. A number of State medical societies have included in their resolutions on adoption practice a recommendation that an unmarried mother be referred to a social agency for help with her plans and those pertaining to her child.[10]

Interprofessional discussions concerning the role of the physician, the attorney, and the social worker in adoption have been placing increasing emphasis upon the importance of helping the unmarried mother. One such discussion was at the meeting on adoption sponsored by the Children's Bureau in May 1960 which included representatives of the American Academy of Pediatrics, the American College of Obstetricians and Gynecologists, the American Medical Association, the American Academy of General Practice, the American Bar Association, and the Child Welfare League of America.

The American Hospital Association has also advocated that more attention be given the problems of unmarried mothers by doctors, nurses, and social workers on hospital staffs.[11]

Many legal problems pertaining to the unmarried mother and her child are of mutual concern to these professions. Among them are legal status, rights and responsibilities of the unmarried mother (adult or minor), legal implications if the mother is married but her husband is not the father, paternity proceedings, legal status and rights of the child, responsibilities of the alleged father, and laws pertaining to legitimation, support, guardianship, custody, and adoption. The complexity of these questions is pointed out by Sanford Katz on pages 55–59.

Responsibility for coping with the problems of births out of wedlock rests with no single profession or agency. It is, as Maud Morlock long ago pointed out, a community responsibility.[12]

Of course, the best way to stop the spread of any social or health problem is to prevent it rather than treat it. Prevention is also a community responsibility, as Patricia Garland makes clear in her article on pages 71–75. While the many knowns and unknowns intertwined in the problem of illegitimacy leave little hope of eliminating this age-old problem, communities can alleviate many of the conditions which tend to aggravate the confusions that are behind so much of it. We may not have all the answers but we do have some and it is up to us to apply them.

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[1] Josselyn, Irene M.: What we know of the unmarried mother. Paper delivered at the National Conference of Social Work, 1953.

[2] Young, Leontine: Out of wedlock. McGraw-Hill, New York. 1954.

[3] Pakter, Jean; Rosner, Henry J.; Jacobziner, Harold; Greenstein, Frieda: Out-of-wedlock births in New York City. I. Sociological aspects. *American Journal of Public Health,* May 1961.

[4] Davis (Sandusky), Annie Lee: Attitudes toward minority groups; their effect on social services for unmarried mothers. *The Child,* December 1948.

[5] Vincent, Clark E.: Unmarried mothers. The Free Press of Glencoe, New York. 1961.

[6] Herzog, Elizabeth: Unmarried mothers; some questions to be answered and some answers to be questioned. *Child Welfare,* October 1962.

[7] U.S. Department of Health, Education, and Welfare, Social Security Administration, Bureau of Public Assistance: Illegitimacy and its impact on the aid to dependent children program. April 1960.

[8] North Carolina Conference on Social Service: Problem of births out of wedlock. Raleigh, April 1959. (Mimeographed.)

[9] Bernstein, Blanche; Sauber, Mignon: Deterrents to early prenatal care and social services among women pregnant out of wedlock. Community Council of Greater New York for the New York State Department of Social Welfare, New York. June 1960.

[10] Gallagher, Ursula: Interprofessional teamwork to safeguard adoptions. *Children,* May–June 1959.

[11] American Hospital Association: The role of hospitals in services to unmarried parents and in adoptions. Chicago, Ill., 1961.

[12] Morlock, Maud: A community's responsibility for the child born out of wedlock. Federal Security Agency, Social Security Administration, Children's Bureau, 1949. (Mimeographed.)

GAPS IN SERVICES TO UNMARRIED MOTHERS

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RECENT YEARS have seen significant developments in resources and techniques for improving services to unmarried mothers, in relation to medical and social care, psychological treatment, and followup. Yet gaps in services continue as the figures in the first article in this issue indicate. Some communities may lack the resources to meet one or another of the needs; in others, the available services are insufficiently or inappropriately used. Thus, some unmarried mothers may be helped in all areas of need, while others may receive little service other than delivery.

An important question, therefore, is: How are services distributed in relation to various segments of the unmarried mother population? Is it on the basis of need, diagnosis, residence, the plan for the baby, race, or other factors? Related to this is the question of whether every unmarried mother automatically requires the services of a social agency in planning for herself and her baby. Another question is why certain available resources, such as prenatal services, are not used to the extent they are needed.

Medical Care

Prenatal care should receive priority attention in considering the needs of unmarried mothers because of the relatively higher incidence of prematurity, fetal, and perinatal deaths, complications of pregnancy, and maternal mortality associated with inadequate care. Many unmarried pregnant women, particularly those of ethnic and racial minority groups, do not seek such care until late in pregnancy, sometimes not until they are admitted to the hospital in labor or with complications.[1]

Among the practical reasons women have given for not getting prenatal care are problems of transportation, obligations to their other children, reluctance to take time from work, and the like.[2] Other reasons often mentioned are a desire to conceal the pregnancy, particularly from school or welfare personnel, failure to recognize the fact of pregnancy, and fear of the examination.

Some studies[2] indicate that the major deterrent is a lack of awareness of the importance of prenatal care, which in turn is thought to be related to cultural influences and unfamiliarity with preventive health practices among members of racial minorities. In fact, in a number of studies of pregnant women in which marital status has not been specified,[3] the ethnic and cultural influences affecting the use of prenatal services have been found to be similar to those found in the studies of unmarried mothers.

Possibly also an initial indifference toward seeking prenatal care is being reinforced by features of the service offered. Long waits in crowded clinics located at distances from home, perfunctory encounters with changing staff, lack of privacy, and the like do not offer effective counterinfluences to indifference, whether the indifference is related to real difficulties, or intrapsychic, or cultural factors.

The conduct of the examination can also deter girls, particularly adolescents, from continuing in care. Despite the sexual laxity which their out-of-wedlock pregnancy implies, many of them possess a large measure of modesty. They can be fearful and highly vulnerable to slights, real or fancied, and frequently need the reassurance which comes with sensitive handling in an atmosphere of privacy. Word gets around quickly in crowded neighborhoods and prospective patients can be kept away when the service is unfavorably reported by others.

The eligibility requirements of tax-supported services in relation to residence, income, or revealing the name of the putative father can also be deterrents. The woman for whom it takes some effort to get to the clinic anyway can easily be discouraged on learning that she must submit to a means test, that the baby's father must be involved, or that she must leave without seeing a doctor because she has come to the wrong hospital.

A program for reaching a greater proportion of unmarried mothers with prenatal care, therefore, must take into account factors both in the patients and in the services which may be presenting obstacles to care. Such a program would include emphasis on the importance of health and prenatal care in regular programs of family life education; efforts toward referrals to medical resources and hospital social service departments; the relaxation of eligibility requirements for prenatal care; and sympathetic attention to each woman served, including the provision of help with the practical problems she faces.

Among the measures being tried here and there in an effort to reduce barriers to prenatal care are: the establishment of local health centers related to a parent hospital; purchase of service by the municipality from voluntary hospitals more conveniently located to the patient and less crowded than the public hospitals; diagnostic screening to determine the frequency of clinic visits; and the strategic use of public health nurses and nurse-midwives to relieve the pressure on medical staff.[4] Although these measures are not directed specifically toward unmarried mothers, improvements which make the service more acceptable to pregnant women in general are likely to make it more acceptable to unmarried pregnant women, particularly if it is provided with the discretion which their out-of-wedlock status dictates.

Many women who cannot meet the full costs of private medical and hospital care are unable to make use of the public services and, therefore, fail to obtain adequate care. They may be ineligible for public service because they are nonresident or nonindigent. Or, if eligible, they may be psychologically unready to accept the conditions under which public care is given, or there may be other indications for continuing with the physician to whom they went initially for diagnosis. In addition to being thus exposed to the hazards of delayed medical care, these women can become susceptible to offers of help in exchange for an adoptable baby. Under such arrangements, often illegal, the care they receive may be provided by poorly equipped practitioners.

Various measures have been taken to meet this problem. In California[5] a licensed child welfare agency, public or voluntary, can pay medical fees from general fees collected from adoptive parents. In the State of Washington, a statewide voluntary agency, the Children's Home Society of Washington, has arranged with private physicians and training hospitals to provide medical care for the unmarried mothers it serves.[6] Adoption agencies have experimented with the provision of direct financial assistance to unmarried mothers for medical care.[7] Also, most maternity homes adjust fees according to need.

In Connecticut, the State department of health, through its maternal and child health division, has developed a comprehensive program in cooperation with key medical and social agencies and the State medical society, which provides for the payment of medical fees for the prenatal and obstetrical care of unmarried mothers and for their referral to the appropriate agencies for social services.[8]

Federal regulation of interstate adoption placement may be indicated for control of the more flagrant practices of exchanging medical care for babies.

Social Care

Major social care for unmarried mothers—living arrangements, financial assistance, legal services, and help with plans for the baby—may be provided by voluntary agencies, child welfare or financial assistance departments of public agencies, or through hospital social service departments. Which of these services a girl uses depends frequently upon whether she keeps her baby or relinquishes it for adoption. Since this choice is apt to be related to ethnic and racial factors, Negro unmarried mothers are likely to receive less than an adequate share of the community's services.[9]

In reviewing a series of reports on services to unmarried mothers and in conversations with caseworkers, neighborhood group workers, public health nurses, and others, I have received the impression that recent developments in the function and structure of many voluntary agencies may be resulting in underservice to a substantial proportion of the unmarried mother population. Many voluntary child-placing agencies in recent years have tended to define their function in terms of adoption, and many maternity homes, oriented primarily toward shelter for concealment, tend to give priority to mothers who plan to relinquish their babies, or are sought out by such mothers. Recent figures from a national association of maternity homes indicate that in 1961, 79 percent of the live babies born to their clients were released for adoption and 13 percent were kept by their mothers. (Plans for 8 percent had not been completed.)[10] With a chronic shortage of Negro adoptive homes, most Negro unmarried mothers have little choice but to keep their babies, which all but rules out the specialized voluntary agencies as a source of help for them. Some maternity homes are frankly or indirectly discriminatory in their admission policies.

As a one-parent family, an unmarried mother and her child, whatever their racial origins, should be able to profit by the help of a voluntary family agency, if there is one in the community. Yet experience indicates that unmarried mothers of minority background and low socioeconomic status make minimal use of voluntary family service agencies. In this respect they have much in common with other hard-to-reach families.

In many metropolitan areas the district office of the voluntary family service agency has been centralized in the core city or has moved to the suburbs. Thus, to obtain service requires time, carfare, and a commitment to living "by the calendar and the clock" which the potential client's past experience may have led her to believe are not worth the effort. Or the type of service offered may require an understanding of the technique of being helped through talking, a concept which may be alien or even threatening to her. The net effect is that the voluntary agencies, while theoretically available, are actually inaccessible to many unmarried mothers.

Most hospital social service departments are chronically understaffed. Although a few voluntary hospitals have recently established policies of 100 percent social service coverage for unmarried maternity patients, the majority of hospital social service departments would find such a policy difficult, if not impossible, to carry out in practice.[9] Even with partial coverage, time for meaningful casework contacts is limited. With the principal focus necessarily on keeping the patient in prenatal care, there is little opportunity for the worker to give sustained help, or to follow through on referrals to other social agencies.

Eighty-five percent of the hospitals in the United States have no social service departments,[11] and therefore provide no social care for women who are delivered in them. Moreover, many public hospitals which do have social service staffs discharge their maternity patients 24 to 48 hours after delivery, with the result that the woman who does not come to the hospital until time for delivery may never be seen by a social worker.

One of the approximately 190 maternity homes throughout the country which in 1960 provided service and care to some 20,000 unwed expectant mothers—only about one-tenth of all those who gave birth out of wedlock during the year.

In New York City, an attempt is being made in a child health station in an overpopulated low-income district to demonstrate the possibility of bringing unmarried mothers of such areas into continuous social care after delivery through the coordinated efforts of medical, nursing, and social service staff. The project was established after a study of unmarried mothers in two such areas resulted in the recommendation that direct social services be provided in the well-baby program.[12]

With the extended availability of Federal funds for child welfare services, the implementation of the 1956 and 1962 amendments to the Social Security Act which place an emphasis on services in public assistance, and the closer coordination of aid to families with dependent children and child welfare services, some of the hitherto unmet needs of unmarried pregnant women may be taken care of by public agencies. The extension of services and staff training in the public programs and the recent orientation of the aid-to-dependent-children program to a family-focused service should allow for greater appreciation of some of the problems which are specific to the unmarried mother and her child as they face the dual hazards of dependency and illegitimacy, which many of them (already faced with problems of racial discrimination) must cope with day by day.

The mother may need help in carrying out the nurturing and homemaking functions with competence and a sense of achievement. She may also need guidance in giving her out-of-wedlock child an interpretation of his parentage which will be comprehensible and more acceptable to him. Inservice training programs can be directed toward helping workers to develop skills in identifying and dealing helpfully with such special needs. They may also help workers carry out the processes of locating a putative father, of establishing paternity, or of assessing the suitability of a home with greater regard for the probable impact on the child.

When new public welfare services are initiated, taxpayers and legislators are likely to look for reassurance about probable increased costs. A number of projects in the last decade have focused on this question. They have demonstrated that the added expenses can sometimes be more than compensated for when the worker, with smaller caseloads and increased skills, is able to motivate the client toward self-dependence. However, while self-dependence can be a salutary achievement for some families, judgments about the effectiveness of programs intended for the benefit of children should rest on sound principles of child health and welfare, and not entirely on the number of families who achieve self-support. Moreover, services cannot compensate for inadequate grants, and the level of living which the allowance provides for can influence the effectiveness of the services.

The recent amendments to the Social Security Act undoubtedly will represent a major stride forward in the development of services to unmarried mothers. However, since their implementation is ultimately decided in the individual States, geography can still be a principal determinant in the help a particular unmarried mother receives. Expectant mothers who cannot provide for their basic maintenance because of residence requirements for financial assistance or the inadequacy of grants are susceptible to the same questionable offers of help in exchange for an adoptable baby as mothers seeking medical care.

Concern is often expressed in regard to the "invisible" unmarried mothers—the self-maintaining women, frequently nonresidents, who make private arrangements for medical care and independent, though not necessarily illegal, adoption plans for their babies. Some of the mothers who release their babies under these circumstances may not be providing adequate protection for them and may also be depriving themselves of needed counseling.

Publicity campaigns, conducted by voluntary agencies, frequently in cooperation with public agencies, to make available services more widely known have been directed toward the unmarried mothers themselves, as well as toward physicians, attorneys, and others who might be in a position to influence their decisions. Frequently, though not always, these campaigns are based on the assumption that the baby will be relinquished for adoption. This suggests the need for careful thought to the ultimate effect which a recruitment program is likely to have on the total allocation of social services. For unless staff is expanded, a redefinition of agency function is usually called for if an unmanageable increase in caseload is to be avoided. This redefinition of function often results in the withdrawal of the voluntary agency services from the nonwhite girl of low social economic status who keeps her baby.

Except for data obtained by Vincent[13] from physicians who had contact with unmarried mothers as patients, the writer has been unable to locate any firsthand information about the self-directing, unrecorded unmarried mothers. How many of these there are is unknown. However, it might be surmised that many such women conduct their affairs without agency help, in a way that enables them to terminate their unmarried-mother status with as few complications as possible. There is little evidence to indicate whether or not they perceive themselves or their babies as being deprived of services.

Psychological Treatment

The very fact of unmarried motherhood is likely to have emotional and psychological repercussions. Therefore, the separation in this article of psychological treatment from other kinds of help may appear to be artificial. However, the allocation of services as it occurs in some communities does produce the effect of a separation.

Psychological treatment for unmarried mothers is usually associated with services from voluntary agencies. For the most part it is provided by personnel—social workers, psychologists, and psychiatrists—who are oriented to a diagnostic and treatment function directed toward helping the unmarried mother to understand the emotional conflicts which presumably led to her out-of-wedlock pregnancy and to enable her to deal with the psychological problems related to the experience of unmarried motherhood.

This service, usually given through verbal exchanges in individual interviews, may sometimes reduce the psychological hazards to the mother, and so may help to insure a sound plan for the baby.

Psychological treatment is available principally to clients of voluntary agencies: usually white girls who plan to relinquish their babies. It is becoming a growing feature in maternity homes which serve only about 10 percent of the unmarried mother population per year. With casework services, psychiatric consultation and treatment, psychological testing, group psychotherapy, and the like, some maternity homes are taking on the character of small psychiatric centers; a few are providing practice training to psychiatrists.

When this kind of programing is dictated by assumptions that pathology is all but universal among unmarried mothers and that more service is equivalent to better service, it may be open to some question. The climate of illness such an approach generates, the continuous focus on self which it encourages, and the image of the unmarried mother which it tends to project raise some doubts as to its universal helpfulness. Moreover, whether a proliferation of services in relation to a small segment of a client population constitutes the most effective allocation of a community's resources, when large numbers are scarcely receiving basic services, is another question that needs further consideration.

Psychological treatment, like social care, is minimally available to Negro unmarried mothers. In fact, the psychodynamic concepts which frequently underlie the diagnostic formulations applied to white middle-class unmarried mothers, and the treatment procedures that flow from these concepts are seldom encountered in relation to Negro unmarried mothers of lower socioeconomic classes. This suggests that adaptations of the accustomed approaches to treatment and the development of new techniques may be indicated for bringing into significant treatment relationships those unmarried mothers who need help with their emotional problems but for whom the conventional methods of treatment are not appropriate.

Followup Care

It is often assumed that most unmarried mothers need continued service after they have weathered the more acute phase of their experience. Some obviously need help with practical plans—securing educational or vocational guidance, interim living arrangements, and the like. However, the fact that most unmarried mothers tend to terminate contact with the social agency after concluding a plan for the baby is regarded as a serious omission in treatment also because they thus cut themselves off from psychological help at a time when unresolved emotional conflicts can cause trouble. Slavson and MacLennan, in reporting on a project to provide group therapy to unmarried mothers after delivery, indicate that attempts to keep unmarried mothers in followup treatment were not significantly successful.[14] A pilot project to test the effectiveness of an intensive reaching-out program in relation to this problem is currently underway at the St. Mary's Asylum and Foundling Hospital in Boston, with Federal funds made available through the Children's Bureau.

The reasons why so many unmarried mothers are reluctant to continue in followup treatment have not been systematically studied. Explanations which relate this resistance to the nature of their emotional disturbances are in many instances based on speculation. It is therefore difficult to say to what extent the failure to reach unmarried mothers with followup care constitutes a gap in service, to what extent it indicates no further need on the part of the girl, or what else it might mean.

Conclusions

When a community is faced with the problem of allocating its resources for effective services to unmarried mothers, the overriding considerations in establishing priorities should be individual diagnosis and need and the full use of available resources. However, the distribution of services is often influenced by other factors, especially assumptions about culture and causation in relation to illegitimacy.

For example, theories about cultural influences regarding sexual permissiveness and the acceptance of illegitimacy among Negroes imply that most Negro unmarried mothers do not require the protection of shelter care. Yet this belief can be effectively challenged by the results of recent studies [2,15] and by the number of Negroes who apply for shelter care when it is available to them. On the other hand, the pathology-oriented theory of causation in relation to unmarried motherhood among white middle-class girls may account for an overemphasis on psychological service for the clients of some voluntary agencies, particularly the readily accessible residents of some maternity homes.

As a community gives critical attention to its practices in allocating its resources, it may find that improvements in services to unmarried mothers will depend less on the establishment of new services than on the redistribution of existing ones. In any event, all appropriate resources and personnel—including public health nurses, neighborhood group workers, and others—should be available to all unmarried mothers in need of their services. Moreover, a start needs to be made toward developing criteria for determining who does need services, who does not, and what kinds of services are appropriate in a particular situation.

This means in effect that many agencies will need to rethink their policies and the methods to which they have long been committed and try to see themselves as part of a total community service rather than in terms of individual agency function. It means that full attention must be given the unmarried mother in her total situation, including medical, social, psychological, and cultural aspects, and in relation to her normal as well as her special needs. The total situation for many unmarried mothers includes enduring experiences of poverty and discrimination and having a distrust of the future which conditions their expectations of the community welfare services.

Gaps in services are frequently associated with gaps in knowledge. Not much is known about the interaction between the biological factors of pregnancy and the crisis produced by out-of-wedlock pregnancy and its implications for specific therapeutic procedures during the period of crisis. Neither is much known about the potentials for growth or damage in the unmarried mother's relationship with her baby and whether the growing trend toward eliminating nurseries from maternity homes is a service or a disservice to the child or the mother. We do not know whether unmarried mothers who have surrended their babies have problems in relation to their first in-wedlock babies, nor whether they can be helped to anticipate possible problems and to recognize a need for help so that they will seek it if necessary.

Among the many unmet needs not discussed in this article because of space limitations are: publicly supported maternity homes, now completely lacking; interim planning with the unmarried mother pending admission to shelter care; planning with the mother for the care of the unadoptable baby whom she had planned before birth to relinquish for adoption; education for the school-age girl [see p. 60]; legal problems [see p. 55]; and others.

However one interprets unmet needs, measures for improving services should insure that no unmarried mother is denied help because of race, residence, her plans for her baby, or other tangential factors; that every unmarried mother has the kind of prenatal care and nutrition which are essential to her own and her baby's health; and that any unmarried mother can have access to the range of other services—social, psychological, or followup—according to her individual needs and capacities.

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[1] Pakter, Jean; Rosner, Henry J.; Jacobziner, Harold; Greenstein, Frieda: Out-of-wedlock births in New York City. II. Medical aspects. *American Journal of Public Health,* June 1961.

[2] Bernstein, Blanche; Sauber, Mignon: Deterrents to early prenatal care and social services among women pregnant out of wedlock. Community Council of Greater New York for the New York State Department of Social Welfare, New York. June 1960.

[3] Monahan, Howard B.; Spencer, Esther C.: Deterrents to prenatal care. *Children,* May–June 1962.

[4] Gold, Edwin M.: A broad view of maternity care. *Children,* March–April 1962.

[5] Heath, Walter A.: California's maternity care program for unwed mothers. *Child Welfare,* May 1961.

[6] Children's Home Society of Washington: Unpublished report and correspondence. Seattle, Wash.

[7] Donnell, Catherine: Financial assistance in an adoption agency. *Social Casework,* January 1950.

[8] Curtis, Hester B.; deRongé, Alberta: Medical and social care for unmarried mothers. *Children,* September–October 1957.

[9] Rashbaum, William; Rehr, Helen; Paneth, Janice; Greenberg, Martin: Use of social services by unmarried mothers. *Children,* January–February 1963.

[10] Florence Crittenton Association of America: Unwed mothers—selected facts and service statistics. Based on reports of FCAA member agencies, 1961. Chicago, Ill., May 1962.

[11] American Hospital Association: Hospital statistics, 1961. *Hospitals* (Part Two), Aug. 1, 1962.

[12] Bleiberg, Nina; Jacobziner, Harold; Rich, Herbert; Merchant, Roland: Young unmarried mothers in child health stations of two New York City districts. *American Journal of Public Health,* December 1962.

[13] Vincent, Clark E.: Unmarried mothers. The Free Press of Glencoe, New York. 1961.

[14] Slavson, S. R.; MacLennan, Beryce: Unmarried mothers. *In* The fields of group psychotherapy. (S. R. Slavson, ed.) International Universities Press, New York. 1956.

[15] Greenleigh Associates: Facts, fallacies and future; a study of the aid to dependent children program of Cook County, Illinois. New York. 1960.

LEGAL PROTECTIONS FOR THE UNMARRIED MOTHER AND HER CHILD

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THE LEGAL PROBLEMS that may beset teenage unmarried mothers vary with each girl. Some questions, however, are of common concern. How does the fact that an unmarried mother is a minor affect her right to bring a suit against the father? Who must support the illegitimate child? Can a minor unwed mother freely give up her child for adoption? Whose consent is necessary? Does minority affect the right to have custody of one's illegitimate child?

In many instances the answers to these questions depend upon the statutes of the State in which the girl resides. For this reason, the reader is warned not to interpret the general statements that follow as applicable to all minor unmarried mothers. While courts which deal with family law are particularly concerned with all the facts in each case, they must still be guided by what is written in the statutes.

The illegitimate child is at a great disadvantage. Not only is there a social stigma attached to his status, but he is also deprived of certain rights and responsibilities.

Legitimacy is regarded by the law to be a matter of personal status. There is a difference between a statute which merely enables a natural child when recognized by his parents to inherit and a statute which legitimates such a child. There is also a difference between methods of legitimation and proceedings to establish paternity—known in law as bastardy proceedings. A child may be illegitimate, yet still inherit from his father under certain conditions. For example, in some States an illegitimate child may inherit from his father if the father has formally recognized the child as his own.[1] In many States, however, the conditions that must be met in order to confer inheritance rights on the illegitimate child are the marriage of the child's natural parents and the formal recognition of the child by his father. These conditions also often serve to legitimate the child.

Thus an illegitimate child might have inheritance rights and might be supported by his father, but, unless the father legitimates his child in a prescribed manner, his child is illegitimate—a status which society has generally resented.

A few States no longer denote illegitimacy on a child's birth certificate, in order to protect the child from undesirable publicity. However, there are research advantages for the recording of such information. Therefore, the Federal Children's Bureau has recommended that information concerning legitimacy status and medical details should be recorded on the birth certificate in a detachable section which can be filed separately so that the information will not be made known to school authorities when a child is enrolled in school or to other persons to whom it is sometimes necessary to show a birth certificate.[2]

Not all fathers are eager to acknowledge or even to legitimate their illegitimate children. Many unwed mothers, regardless of age, have to institute legal proceedings to establish the paternity of the child and to force the father to support his child. The character of these proceedings varies in the different States. Typically, however, a bastardy proceeding resembles a criminal action, yet the substance and effect of the proceeding are like those in a civil action.

Establishing Paternity

Bastardy proceedings are normally instituted by the mother. If she fails to do so, however, some States may themselves bring the action. In States in which bastardy proceedings have been considered as essentially civil actions, it has been held that the unmarried mother who is a minor must be represented by a guardian *ad litem*, or next friend.[3] On the other hand, some States subscribe to the view that a guardian *ad litem* is unnecessary because the State is the real plaintiff in the case, prosecuting the putative father in order to secure funds for the child's maintenance. In these States the courts take the point of view that the proceeding is aimed at preventing the illegitimate child from becoming a public charge, and that the minor unwed mother is merely a witness for the prosecution.

Conceivably, in some instances, a minor unmarried mother, for some monetary consideration, might enter into an agreement with the putative father not to institute bastardy proceedings.[4] She might do so because: (1) she is not absolutely certain that the presumed father of her child is in fact the father or that she would be able to convince the court of this; or (2) neither she nor the father wants to create a scandal or provoke publicity by instituting a bastardy proceeding. A few courts have held that if a minor mother enters into such an agreement and there is no evidence of fraud or duress, the agreement is binding and is a bar to further bastardy proceedings. Other courts have applied to such agreements the same general rule applicable to infants' contracts: An infant can void any contract or agreement to release his rights. This principle of contracts law is based upon the presumption that infants do not have sufficient discretion to put a just value on their property or rights and should therefore be protected.

Some States provide statutory safeguards for the mother in a minor's release of a bastardy claim. Such a release must be approved by a court.

While in the past it was generally believed that a father had a moral obligation to support his child born out of wedlock, the common law did not provide for the legal implementation of this moral duty. Not even the child's mother was liable for his support. The illegitimate child was regarded as *filius nullius* (nobody's child). Today, however, all States require the mother of an illegitimate child to support the child and, after paternity has been established, the father to contribute to the support. In many instances the father is required to aid in the expenses of the mother's pregnancy and the child's birth, upbringing, and education. Some States provide for the support payments to continue from the child's infancy to a specified age or to his majority.

There are indirect as well as direct means of requiring a father to support his illegitimate child. Some States do this through their poor laws, which place illegitimate children within the category of indigent relatives whom a nonindigent must support. Other States accomplish this objective through criminal laws which provide penalties for the abandonment and nonsupport of children, including illegitimate children. Still others provide for the enforcement of the father's duty of support through the bastardy laws which prescribe legal procedures for the determination of paternity.

Grandparents' Obligation

A problem often encountered in relation to minor unmarried mothers concerns the question of whether the mother's parents have an obligation to support her illegitimate child. Often a teenage unmarried mother continues to live at the home of her parents after the birth of her baby, attending school while her mother cares for her child. In such a situation the illegitimate child and his mother tend to be reared as siblings. Thus the question arises: Do grandparents, maternal or paternal, have responsibility to support their illegitimate grandchild? State statutes guide the courts in their efforts to answer this question.

Two Pennsylvania cases are interesting for the approaches taken by two different county courts in dealing with this problem.

In one case,[5] a petition for support of a poor person was brought by a child placement agency, the Children's Bureau of the Community Service of the County of Lancaster, against the maternal grandmother of an illegitimate child. These were the facts: When the defendant's daughter, Jessie, was 16, she gave birth to a son. The father of the child was unknown. With the consent of Jessie and her mother, the child was placed in foster care by the child placement agency. At the time the agency filed the petition for support, the child had been in foster care for a year. The agency wanted reimbursement from the child's maternal grandmother for the cost of keeping the child in foster care.

The question before the court was: Can the maternal grandmother of a dependent illegitimate child be held liable for the support of that child, where the mother of the child is a minor and is not able to support him? The court held that the maternal grandmother was liable for the support of the child from the date of the case, but not retroactively.

The Lancaster County court relied on two Pennsylvania statutes to reach its decision: a poor law statute and a decedents' estates statute. Section 1012 of the Pennsylvania General Poor Relief Act reads: "The husband, wife, children, father, mother, grandparents, and grandchildren respectively of every poor person shall at their own charge, being of sufficient ability, relieve and maintain such poor person at such rate as the court of quarter sessions of the county where such poor person resides shall order and direct."

Did "grandparents" in this statute include Jessie's mother? In order to decide this issue, the court had to decide whether there was a legal relationship between a grandparent and an illegitimate grandchild. The court found that there was such a legal relationship by looking to the decedents' estates statute and finding that maternal grandparents of an illegitimate child can inherit from that child and that the child can inherit from maternal grandparents.

For the same reason that the Lancaster County court determined that there was a legal relationship between an illegitimate child and its *maternal* grandparents, thus making those grandparents "responsible relatives" within the meaning of the poor laws, the Allegheny County court held in another case [6] that the *paternal* grandparents of an illegitimate child had no legal relationship to that child. In that case the paternal grandfather of a child of a bigamous marriage brought an action to dismiss proceedings in which an order had been made against him to continue to contribute toward the support of the child. The grandfather had made some effort to support the child in the past after his son's abandonment of the child and the mother. The court reached the decision, apparently with some reluctance, that it would be unfair to saddle a paternal grandfather with the responsibility of supporting his illegitimate grandchild without giving the grandparent reciprocal inheritance rights.

Here was an invitation for the legislature to remedy this kind of situation. The Pennsylvania Legislature has not taken up this invitation. Instead it has repealed that section of the support laws requiring grandparents to support indigent grandchildren.

Adoption

Generally when illegitimate childern are released for adoption, State statutes require the consent of the mother only. In some States the father's consent is required if he has acknowledged the child, particularly if there has been legitimation of the child by the marriage of his natural parents to one another and the acknowledgment of the child by the father. Legitimation of the child by marriage of the natural parents after the mother has given consent to adoption does not always mean that the father's consent is also required.

State statutes differ regarding the problem of whether the consent of the parents or guardian of a minor parent must accompany the minor unmarried mother's consent to the adoption of her child.[7] Statutes in Arizona, the District of Columbia, Kansas, and Maryland specifically state that minority is not a bar to consent. There is much to be said for this approach. Sometimes parents can do great damage to their child and their illegitimate grandchild by withholding their consent. An older teenage unwed mother might with good reason want to keep her pregnancy and the birth of her child secret.

In its "Legislative Guides for the Termination of Parental Rights and Responsibilities and the Adoption of Children," [8] the Federal Children's Bureau has considered the effect of the mother's minority on her consent to the termination of her rights in her child. Section 6 of the termination guide requires that a minor mother's parent or guardian must be notified of the termination proceeding, "unless the court is satisfied, in the exercise of its discretion, that such notice is not in the best interest of said minor and that it would serve no useful purpose." Presumably, since a social study would be made in each case of the termination of a mother's rights and the adoption is filed by first or second degree relatives that study in making his decision regarding the advisability of notifying the minor mother's parents or guardian. In an adoption in which the petition for adoption is filed by first or second degree relatives of the child, the adoption guide would require that a minor parent's consent be concurred in by her parents or guardian.

A minor unwed mother must be protected from making a hasty and improvident decision regarding her child. A wise approach is taken by the provision in the adoption guide and many other statutes which require acknowledgment and attestation before a court or a notary of a mother's consent to the termination of her rights in her child.

A problem of getting consent from the unmarried mother's parents also comes up when a minor unmarried pregnant girl seeks medical care. Most hospitals and clinics require the consent of parents before providing any care to a minor because of the parents' legal rights in their minor child.

Custody

In regard to custody, courts subscribe to a generally accepted doctrine: A mother is the natural guardian of her illegitimate child, and as such has the legal right to his custody, care, and control, superior to the right of the father or any other person.

The policy underlying this rule seems to be that while the identity of the father of the illegitimate child may be doubtful, there can be no doubt as to the identity of the mother. Since the obligation to care for and to support the illegitimate child is primarily imposed on the mother, she should have custody to enable her to discharge that obligation adequately. There is also a presumption in the law that the child's best interests require him to be in the mother's custody.

The mother's right to custody of her illegitimate child is not absolute.[9] It is qualified by the same principle applicable to custody questions generally: The best interests of the child must be a guide.

Thus, in a custody battle between a minor unwed mother and her relatives, if a judge thought it would be in the best interest of the child to allow its mother to maintain custody, he would award custody to her. The age of the mother would be a factor, but the overriding consideration would be the best interests of the child.

Because of the presumption in the law that the illegitimate child's best interests require the child to be in the mother's custody, the burden is upon the person disputing the mother's custody to show why the general rule should not apply.

One possible antagonist to the mother in her attempt to maintain custody of her illegitimate child might be the father. What are his rights? Once again it must be said that the mother has superior rights to custody so long as it is in the child's best interest for him to remain in her custody. As between the competing interests of the father and other relatives, courts generally prefer the father.[10] Of course, here too the evidence must show that the father will make a suitable parent and the child's interest will ultimately be furthered by his being put in the father's custody.

Custody Agreements

Sometimes an unwed mother transfers the custody of her child to another person or persons. The arrangement might be made through a formal or an informal agreement. It might be permanent or temporary. This raises certain questions. Must an unwed mother take any special measures if she wants to arrange informally for another person (perhaps her mother) to take care of her child? Is a formal agreement of this nature legally binding on the unwed mother? Does the fact that she is a minor make a difference?

In a case recently before the Colorado Supreme Court,[11] an action was brought by the State to determine dependency and neglect of an illegitimate child. The child's mother had been arrested on a charge of forgery and sent to the penitentiary. Before incarceration she had taken the child to his grandmother, her mother, for care until her release from prison. At the trial to determine neglect, there was no disclosure of facts suggesting that the grandmother was mistreating the child. Presumably the proceeding was brought and carried to its conclusion on the sole assumption that, since the illegitimate child was not being cared for by either his father or his mother, the child was in fact neglected and dependent.

The trial court declared that it was necessary for the mother to obtain the consent of the court before putting the child in care of her mother. The Colorado Supreme Court found this ruling to be in error. The language of the court is important because it reflects an approach taken by many courts and is eminently sensible.

The court said:

> Clearly it is *not* the law that before a child can be placed by a parent in temporary custody of a relative, permission must be first obtained from the court. Nor is it the law that custody orders must issue, and that the court must appoint the persons selected by the parent officially as guardian. . . . If, through arrangements made by the parent, the child is being properly cared for by those who have a genuine interest in its welfare, the fact that the mother has obtained such help and has sought out and procured proper care for the child is evidence that the parent is not neglecting the child.

A formal agreement transferring custody of an illegitimate child from his mother to somebody else may or may not be enforced, depending upon the State in which the agreement is made or in which it is to be enforced. Some States have laws stating clearly that a permanent transfer of custody of a child from his natural parents to another person is invalid because it is contrary to public policy.[12] In States where the law is not explicit on this subject, some courts have upheld such a transfer if it is in the best interests of the child. Other States have statutes authorizing such a transfer.

In a recent Georgia case,[13] an issue before the court was whether a contract made by a 19-year-old woman and her husband (not the father of the illegitimate child) was effective to waive her parental control over her minor child. The court, following an earlier Georgia case,[14] stated that an infant wife could not waive her parental control over her child. In fact, she could apply to the proper court to regain custody of the child if he were in the custody of someone else.

Presumably the courts apply the general principles of the law of infants' contracts to situations involving the transfer of custody. The teenage unwed mother, then, is protected from the results of a hasty decision to transfer custody of her illegitimate child. If she does make a decision to transfer custody, she can change her mind later and void the contract.

Conclusion

The fact that an unwed mother is a minor is relevant insofar as the law is concerned. Because of her age, her rights, responsibilities, and liabilities differ in many respects from those of older unwed mothers. For many of the legal principles applicable to minors generally are applicable to the minor unwed mother.

It must be borne in mind that when children are involved in a case, courts are guided by "the best interests of the child" doctrine. While that doctrine is defined in many ways, depending upon the court and judge, it can serve as a useful criterion. The hope is that "the best interests of the child" doctrine will work to protect and benefit not only the illegitimate child but also his mother who, as another child, also deserves special consideration.

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[1] U.S. Department of Health, Education, and Welfare, Social Security Administration, Bureau of Public Assistance: Illegitimacy and its impact on the aid to dependent children program. April 1960.

[2] Federal Security Agency, Social Security Administration, Children's Bureau; and Public Health Service, National Office of Vital Statistics: The confidential nature of birth records. CB Publication No. 332. 1949.

[3] Davis, R. P.: Maintainability of bastardy proceedings by infant prosecutrix in her own name and right. *American Law Reports Annotated,* Second Series, Vol. 50, pp. 1029–1033, 1956.

[4] Oliver, T. J.: Lump-sum compromise and settlement, or release, of bastardy claim or of bastardy or paternity proceedings. *American Law Reports Annotated,* Second Series, Vol. 84, pp. 524–585, 1962.

[5] *In re McAllister,* 31 D. & C. 4 (1937).

[6] *Commonwealth* v. *Campagna,* 40 D. & C. 478 (1940).

[7] Katz, Sanford N.: Judicial and statutory trends in the law of adoption. *The Georgetown Law Journal,* Vol. 51, Fall 1962.

[8] U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau: Legislative guides for the termination of parental rights and responsibilities and the adoption of children. CB Publication No. 394. 1961.

[9] Right of mother to custody of illegitimate child. *American Law Reports Annotated,* Vol. 51, pp. 1501–1517, 1927.

[10] Davis, R. P.: Right of putative father to custody of illegitimate child. *American Law Reports Annotated,* Second Series, Vol. 37, pp. 882–889, 1954.

[11] *Diernfeld* v. *the State of Colorado,* 323 P. 2d 628 (1958).

[12] *Stickles* v. *Reichardt,* 203 *Wis.* 579, 234 N.W. 728 (1931).

[13] *Springstead* v. *Cook,* 215 Ga. 154, 109 S.E. 2d 508 (1959).

[14] *Walker* v. *Walker,* 209 Ga. 490, 74 S.E. 2d 66 (1953).

> They [unmarried mothers] need something as simple and as wonderful as human interest. They need someone strong enough to share the responsibility they cannot carry, to give the direction they lack, and to provide the structure which can put controls on their destructive behavior and encourage what strengths they do have. In other words, they need protective authority that will keep them out of trouble instead of punishment after they are already in it.
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> *Leontine Young, professor of casework, Ohio University, to the 1960 White House Conference on Children and Youth.*

THE SCHOOL AND UNMARRIED MOTHERS

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NEARLY ALL STATES have compulsory education laws. In most States, these laws require young people to attend school until they reach the age of 16, and permit them to attend until they are 18 or 21, or until they finish high school. In practice, these laws have been interpreted to mean that provision must be made for the continued education of all children through grade 12. Not exempted are the slow, the maimed, and the blind. One group only is often overlooked or deliberately excluded. This consists of the teenage girls who are already mothers or who are about to become mothers—many of them without benefit of marriage. Whether or not State education laws apply to these young people varies with the States or is left up to local school systems to determine as they see fit. Yet these young mothers—in spite of the manifestations of their physical maturity—are legally, as well as mentally and emotionally, still children. They are obviously as badly in need of education as other teenagers, if not more so.

Information is not available on the nature or the extent of all educational opportunities for unwed mothers. It is clear, however, that some States have directly contradicted the comprehensiveness of their educational objectives with regulations or practices which exclude girls who are pregnant or who have already had a child. Many States by law or regulation deny educational opportunities to out-of-State girls who are seeking anonymity away from home. Some even forbid local school systems to make special provisions for any unwed mother.[1] Such restrictions, deriving presumably from moralistic and punitive attitudes, may actually be self-defeating, for society will be the loser if these girls' problems are compounded by continued ignorance.

The schools, in spite of the constant criticism they receive, do represent an avenue for transmitting society's standards of moral behavior. For unmarried mothers—especially those under 16—some continuity of school experience may be not only an opportunity for receiving a much needed education but also the only real hope of staying out of trouble. Such girls usually release their babies for adoption or turn them over to their own mothers for support and care. These girls are too young for jobs, even if they wish to remain out of school. Hence all adult roles are denied to them. They have no peer group available, no means of support, no *raison d'être*. And they are vulnerable to further overtures from boys who themselves run no equivalent risks.

For the older unmarried mother who will be seeking employment after delivery, vocational guidance and training are extremely important. These functions are traditional school functions.

The social-educational responsibilities of schools may be debatable, but their social influence is not. Parsons [2] stresses the fact that school is not only a vital agency for helping young people adapt to society, but also a channel through which they select their future status in society. Thus when an unmarried mother must forego further education, the chances for her social improvement are diminished.

All young people need the experience of achievement. According to Vincent, many unmarried mothers have not had this experience, have not even been free to fail while trying, and hence have developed a "paralysis of workmanship." [3] They postpone, partially complete, retreat, or are unable to decide. Nowhere is this as manifest nor as crucial as in school.

The pressure mounts in the later school years. As Parsons has pointed out, the elementary school tends to focus on the level of capacity; the secondary school focuses on qualitative achievement.[2] The unsure, the work-paralyzed student is increasingly conspicuous. Although research indicates that *social* success has the highest status for the teenage girl,[4] there is reason to believe that social status itself is partially dependent upon reasonable *academic* success. Those girls who cannot achieve academically may try to achieve socially by attempting to demonstrate their adequacy and success in sexual and reproductive roles. Such girls need individual attention to help them with their learning problems.

Many unmarried mothers are especially lacking in the skills of communication.[5] Without attending school they have no further opportunity for learning these skills.

Fear is undoubtedly one of the major factors behind the community pressures which result in unmarried mothers being excluded from school, fear that sexual activity will be sanctioned, hence encouraged. But since the boys involved are rarely, if ever, excluded from school, the protection afforded others by putting the luckless girls "out of sight and out of mind" seems somewhat illusory. A far greater protection for the girl, the boy, and their schoolmates would be efforts on the part of the school system to help her, and the rest of the students to reach a greater understanding of the world in which they are a part. This requires a comprehensive and variegated program aimed at providing continuity of education for all children until they finish high school—including girls who are pregnant and those who have delivered, *whether or not they keep their babies.*

Identification and Referral

Besides their obligation to help the unmarried mother to continue her education, the schools have a responsibility for helping the pregnant student to receive the medical and social services she needs. The school, more than any other community agency, is in the most favorable position for finding the scared, pregnant girl early in her pregnancy and directing her to the appropriate community services.

The identification and referral process is not an easy one, for it requires protection of the girl from curiosity and gossip without condonement of the action which brought her to her present state. It is often hampered by the girl's own fear of being found out in a situation she knows must eventually be discovered, but which out of panic she often tries to hide as long as possible. In many schools, identification is further hampered by a regulation that requires a pregnant girl to be dropped from school as soon as her pregnancy is known.

The school nurse can play a major role in the identification and referral process. If the nurse has a good relationship with the students, and in her behavior toward them has built up a reputation of professional integrity, the troubled girl is apt to go to her with her problem, as she has with the aches and pains she has suffered from time to time. The school social worker—if there is one—has responsibility for working closely with the nurse and the teacher in identifying the girl whose behavior indicates that she is troubled, for making the actual referrals to the appropriate community agencies, and for following through to see what arrangements can be made for the girl's continued schooling as well as for meeting her other needs. Unfortunately, few schools make any consistent attempt to learn what happens to the pregnant girl after she leaves school.

There is no provision for followup if the girl has passed compulsory school age. Therefore, most schools do not even know how many of their school dropouts have left school because of pregnancy.

Instruction During Pregnancy

Even if schools cannot allow pregnant girls in their classrooms, they can—and in some instances do—provide continued educational opportunities for them. In a few places—Portland, Oreg., for example—the school systems include pregnant girls who live at home or in foster homes in their special programs of instruction. Some school systems, as in Seattle, Wash., Toledo, Ohio, and Portland, Oreg., taking advantage of facilities which make it possible to reach the girls in groups, send teachers to maternity homes.

In Portland, Oreg., the school system furnishes the Salvation Army White Shield Home with the services of three half-time teachers who instruct the girls in small groups and individually according to their school level. The public schools also provide three half-time teachers for classes offered at the Boys and Girls Aid Society of Oregon for pregnant girls who live at home or in foster family homes. This program clearly validates the contention that continuation in school is important to these girls. They attend these classes in spite of embarrassment at having to appear in public in order to reach school.

In Seattle, Wash., the Florence Crittenton Home of Seattle, which (with a few exceptions) limits its intake to teenage girls, puts great stress on the continuance of education. Instruction is provided by three full-time teachers from the public school system and the girls are generally expected to attend classes regularly.

In both Portland and Seattle, rather complex record procedures are adhered to which protect the girls from indication on their school transcripts the nature of their circumstances. The records show only that the girls have transferred either to a different school or to a department which includes a number of special schools. The bulk of this record handling is channeled through one high school in each city. Pregnant girls may graduate from high school in ceremonies held for them in the maternity home.

These programs have revealed the meaning that continued schooling can have for girls pregnant out of wedlock. Frances Miller, supervisor of the program for the physically handicapped of the Portland public school system, has noted that "schoolwork seems to be the one stabilizing influence for a meaningful and purposeful activity when a pregnant girl feels overwhelmed by a multitude of problems." And June Peterson, public school teacher assigned to the Florence Crittenton Home in Seattle, has found that some girls who had dropped out of school *prior* to their pregnancies were motivated not only to resume their studies while at the Crittenton Home, but to re-enter regular high school after delivery. Their new-found motivations are a tribute to excellence of instruction and rehabilitation.

In a maternity home, an expectant mother does her schoolwork, an opportunity denied to many unwed mothers.

Many people assume that schools offer educational opportunities to girls who have given up their babies for adoption, the girls returning to their regular schools for instruction. Such, however, is not always the case. Burchinal in his study of *married* students in Iowa reports: "generally girls who were pregnant prior to marriage are not permitted to re-enter school automatically. About one-third of the schools would not even consider re-entering." [6] These findings are, of course, also germane to unmarried mothers.

Post Partum Instruction

However, in Portland and Seattle girls are encouraged to return to regular public schools after delivery. They may choose their previous school or a different one. Moreover, in Seattle girls who were high school seniors while studying at the Crittenton Home are allowed to return to the home after the birth of their baby to finish their schooling, if graduation time is near.

But what happens if the new mother with no husband decides to keep her child? She is, perhaps, the most educationally neglected of all. The choice of keeping her child (or necessity because of lack of other opportunities) is most often made by the nonwhite girl of low economic status and deprived cultural background, who, even more than others, needs help and encouragement in securing further education. The poorly educated deprived girls are the most likely to be links in chains of generations of unmarried mothers. They are also the most likely to have more children out of wedlock.

Philadelphia is the scene of an unusual experiment to provide educational opportunities to such girls. There the public school system and the Berean Institute, a voluntary agency, are collaborating in a program which provides both instruction in child care and vocational education to teenage unmarried mothers. The mothers bring their children by public transportation to the agency each day. The institute provides a day-care program for the babies while the mothers attend classes—in stenography, beauty culture, and academic subjects taught by a teacher provided by the board of education as a part of its extension education service. The mothers take care of their children's needs, including the feeding, and are on call for emergencies related to their babies.

The first 3 years of the project were financed by a grant from the Seybert Institute. Since then the Philadelphia Department of Welfare has contracted with the Berean Institute for continuation and improvement of the service. Funds have been made available by the Pennsylvania State Department of Public Welfare, with Federal financial participation through the State's child welfare services plan.

Now in its fourth year, this program, is reported to be having gratifying results.[7] Many of the mothers are said to be achieving far more in their schoolwork than they ever had previously, and to be finding real satisfaction in their roles as mothers and as family members at home. The grandmothers (the mothers' mothers), often unmarried mothers themselves, are brought into the program and have expressed their approval of it. Not only are they included individually in the planning for the mother and child but are encouraged to participate in group conferences. They are helped to see their appropriate roles. For example, one grandmother said after such participation: "I am now able to be a grandmother . . . at first I felt like the mother."

The Personnel

Providing for the education of unmarried mothers obviously calls for the cooperative efforts of educators and social workers in schools, in school extension programs, in maternity homes, and in other social agencies. The school can make best use of social welfare resources if they have social workers on their own staffs, and social agencies can provide the best service to unmarried mothers by having teachers on theirs. I have already referred to the responsibility of school social workers, as well as nurses, in the identification and referral processes for the unmarried mother. Bowman [8] has illustrated the value of school social workers in the post partum planning for return to school. They can help decide whether the girl should return to the same school or a different one, and whether her program should be academically or vocationally focused.

However, if the members of these professions are to succeed in helping the unmarried mother to educational achievement, they need some affinity for interdisciplinary collaboration. The school social worker must have basic respect for education and be determined to increase the educability of each child by helping him with his social problems. On the other side of the coin, the teacher in the maternity home must believe in the power of education to facilitate the social rehabilitation of her students.

The personnel, however, can only achieve what the institutions of which they are a part themselves are committed to. This means that there must be a closer working together of schools and social agencies all along the line, and a mutual belief in the interdependence of their efforts for the achievement of best results. Perhaps out of working together for those especially troubled girls, the unmarried mothers, they may achieve broader vistas of mutual concern and collaboration.

The Horizons

This cursory review of some of the things being done only points up the possibilities of what might be done to help unmarried mothers continue their education. There are great needs for leadership in this area, publications, research, reciprocity between cities and States, extension and improvement of services, and educational efforts toward prevention of illegitimacy.

It is almost impossible for special educational needs to get substantial nationwide attention without strong lay or professional leadership. Lay leadership often comes from parents of the specific groups of handicapped children needing such services—the mentally retarded, the cerebral palsied, the emotionally disturbed. In the case of unmarried mothers, the parents are either too embarrassed by their daughters' predicament to want to call attention to it, or too far down the social ladder to be able to organize community support. Hence, it falls to the professionals to assume the initiative. However, only a few voices have been raised in the cause of schooling for unwed mothers, most of them from a small section of the Association of Educators for Homebound and Hospitalized Children, itself a small part of the Council for Exceptional Children of the National Education Association.

Leadership, interest, and knowledge depend in part upon publications devoted to the subject. The supply is meager. Some good presentations have been incorporated into institutes and conferences, but have not been extensively distributed. Occasional articles have appeared in the social work journals, but these reach few educators or lay persons.

Research needs and possibilities are legion. For example, a basic study of the nature and extent of school programs for unmarried mothers could well be made by the Office of Education, the Children's Bureau, or one of the major professional organizations. Followup studies might be conducted on "graduates" of present programs. Basic research into the relative weight of social and educational status in association with illegitimacy would be helpful to program planning.

Reciprocal agreements need to be reached between cities within States and between the States so that nonresidents can receive the services they need. Residence requirements are reprehensible enough when applied to applicants for public assistance, but restrictions that prevent girls who are deeply in trouble and are away from home from getting the medical, social, and educational help they need to rehabilitate their lives are indefensible.

It goes without saying that present programs need extension and improvement. As we have noted there *are* some fine examples to be followed, but even these rarely reach all the unmarried mothers in need of further education. The Philadelphia program, for example, which is pioneering in new directions to help girls from deprived backgrounds, can reach only a fraction of the unmarried teenage mothers in the city.

Prevention

Preventive efforts are even more important than remedial measures in attacking any social problem. But the subject of prevention in relation to illegitimacy is both a nebulous and a sensitive one. Pregnancy before marriage does not lend itself to prediction. It is not in itself a social or emotional disorder, although in many instances it is a symptom of a disorder. Therefore, efforts to prevent social disorder may result in the prevention of some potential out-of-wedlock pregnancies.

One possibility is sex education. This is a touchy subject which is often discussed with more heat than light. While many people apparently have strong feelings about the appropriate time, place, and method for giving information about sex to young people, little, if anything, is actually known about the comparative effectiveness of various approaches. In fact, very little is known about the relationship of incomplete or distorted sex information to pregnancy among unmarried teenage girls. Here again research is needed to supplant opinion. We may find, for example, that unmarried mothers have received more rather than less sex information than others, but they may have received it from the wrong sources and in a distorted form.

Another possibility lies in greater efforts to inculcate moral and ethical values in young people through the regular school programs. Derthick [1] has urged the schools to do more in this area. He has received, by implication, support from Vincent,[3] who has written at length about the place of current educational methods in promoting a "fun morality"—the idea that all things are better if they are fun. Can the schools find better ways of educating for nonfun morality? Should they, if they can? Will the incidence of unmarried motherhood decrease through this means?

Some current experiments in education may be suggestive of further experimentation. As indicated in Gross [9] and others, grouping in classes—by intelligence, age, achievement—has become an important consideration in education today. Some of the characteristics of unmarried mothers may have grouping implications for children with these characteristics. For example, various reports indicate that some girls who have become pregnant out of wedlock have need of a close relationship,[7, 8] especially with a mother figure. Perhaps children who give early evidence of having such a need in excess could be especially placed with a motherly teacher or at least *not* with unmotherly cold teachers. Perhaps teachers could place more emphasis on the mother role than the teacher role with such children.

Perhaps, on the other hand, or in addition, we could increase the male influence in the lives of these children. Many unmarried mothers who come from deprived backgrounds have had no father in the home most of their lives, if at all. Adequate male teachers might be even more beneficial to them than motherly females.

We need to pose the questions, whatever the answers, and consider the possibilities for the prevention of illegitimacy as well as the rehabilitation of unmarried mothers.

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[1] Derthick, Laurence C.: Elimination of roadblocks in educating school-age unmarried mothers. Paper presented at annual meeting of Florence Crittenton Homes, Atlantic City, N.J., 1960. (Mimeographed.)

[2] Parsons, Talcott: The school class as a social system: some of its functions in American society. *Harvard Educational Review*, Vol. 29, No. 4, Fall 1959.

[3] Vincent, Clark E.: Unmarried mothers. The Free Press of Glencoe, New York. 1961.

[4] Coleman, James S.: Academic achievement and the structure of competition. *Harvard Educational Review*, Vol. 29, No. 4, Fall 1959.

[5] Berl, Mildred Elliott: An interim school program for unwed mothers. *Child Welfare*, January 1960.

[6] Burchinal, Lee: School policies and school age marriages. *Journal of Family Life Education*, March 1960.

[7] Berean Institute: A positive approach to unmarried mothers. First and second progress reports. Philadelphia, Pa., November 1959 and November 1960.

[8] Bowman, Lola A.: The unmarried mother who is a minor. *Child Welfare*, October 1958.

[9] Gross, Neal: The sociology of education. *In* Sociology today. Basic Books, New York. 1959.

Viewing the problem of illegitimacy whole points up a need for providing . . .

CASEWORK SERVICE FOR UNMARRIED FATHERS

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TRADITIONALLY, in working with the problems of illegitimacy, social agencies, both public and private, have quite naturally focused their attention on the unmarried mother. The father of the child born out of wedlock remains a somewhat nebulous figure, left free to attempt to detach himself physically and emotionally from a problem in which he has been intimately involved. Generally, agencies have seen the father only if he has presented himself or has been asked to come in to contribute financially to the mother's medical expenses or the child's support.

More than 20 years ago, Maud Morlock recommended that agencies provide casework services to fathers of children born out of wedlock and that studies be made of such agency experiences, especially with reference to the skills needed in the interviews, the cooperation of the father with the agency, and the development of his interest in the child.[1] Both the Children's Bureau and the Bureau of Family Services are continuing to advocate such a policy[2] as does the Child Welfare League of America.[3]

Yet a review of the literature reveals that little information about such fathers has accumulated. Assumptions about the putative father and his attitudes have usually been formulated from information and feelings expressed by unmarried mothers. The public usually pictures him as a seducer and deserter, at the same time excusing him with such clichés as "he was just sowing wild oats" or "boys will be boys." Clark E. Vincent, in his recent study of unmarried mothers, states: "Although biologically he is half the cause of illegitimacy, the ratio of studies of the unmarried father to studies of the unwed mother is approximately one to twenty-five."[4]

While the literature contains many references pointing to the desirability of providing casework service to the father, few agencies provide such a service with the same degree of intensity of that being offered to the unwed mother. Lack of trained staff, lack of financial resources have been the primary reasons given for not involving the father in casework services. One must add to these a lack of conviction on the part of many social workers that he can be involved and perhaps some lack of conviction about the value of involving him. This lack of conviction may in turn be due in part to a lack of experience in directly working with the putative fathers as well as to misconceptions about them. One frequently hears that the unmarried father's relationship to the unmarried mother is exploitative, that the relationships between unmarried parents are for the most part fleeting and of a casual nature—generalizations which derive from the public's image of the unmarried father.

In recent years, however, a few agencies have been pioneering in efforts to involve the father in casework service, not only to provide better service to the mother and to make possible better planning for the child, but also for the sake of the father himself and his future behavior and relationships. One of these agencies is Vista Del Mar, a Community Chest agency in Los Angeles, which for the past 6 years has been offering the unwed father the quality of individual help long recognized as essential for the unwed mother.[5]

Experiences at Vista Del Mar, as well as those at St. Elizabeth's Infant Hospital in San Francisco,[6] support its expectation that the teenage father has many of the same problems as the teenage mother. The boys to whom casework service has been provided have been found to be receptive to the help offered and to have been able to use it constructively. They have come from all social and economic walks of life.

Services Offered

Vista Del Mar began its services to the unwed father by reaching out to the teenage father who, if he did not come to the agency with the girl, was standing close by and therefore was accessible. A male caseworker was made available to the boy on the theory that he would respond more favorably to the opportunity of talking to a man because of anticipating greater understanding of his own problems and needs. The social worker could, in a sense, represent a father figure to the troubled boy.

Bringing the teenage father into the agency turned out to be less of a problem than had been expected. The boy either comes spontaneously to the agency with the girl or readily accepts an appointment when this is offered to him. In every instance his parents as well as the girl's parents are contacted by the agency, and the work done with the boy and his family parallels and is integrated with the work done with the girl and her family. Take, for example, the case of 17-year-old Robert L, the father of the child expected by 14-year-old Barbara M.

The two young people had met through a friend. After going together for a relatively brief time, they had decided they were in love and that they would go steady. Although Robert had never had sexual relations with other girls, he knew his friends had and it seemed natural for him to suggest to Barbara that they do the same.

When Barbara became pregnant she was brought to the agency's attention by her parents. After obtaining her permission, the agency got in touch with Robert's parents by phone with the offer of an immediate appointment for them and the boy. Although they at first expressed considerable doubt about the possibility of the agency's being of any help to them and their son, the L's came to the agency with Robert for an initial interview, leaving before he did to give the caseworker a chance to see him alone. They eventually agreed to cooperate with the agency in every way, accepting casework help for themselves as well as Robert, and participating in a financial plan to help pay Barbara's expenses. Throughout all the interviews with them, the caseworker urged them to support Robert in defining and meeting his responsibilities.

Robert himself readily accepted the offer of casework help. He had been stunned and frightened when he learned of Barbara's pregnancy, and began to realize that he had done something wrong. He welcomed the opportunity to talk over his problems in an effort to find out what would be the right thing for him to do.

At the time of the agency's contact with Robert, he was completing his senior year in high school where he had always maintained about average work. After he learned of Barbara's pregnancy, his school grades had begun to drop and he was in real danger of failing, and possibly not graduating.

Robert described his relationship with his mother, who had an overprotective attitude toward him, as being a much easier one than the relationship between himself and his father. His mother and father quarreled a great deal, mostly about him.

Robert had never been close to his father, a rather intense, hard-working man whose job as a salesman kept him away from home a good deal of the time. Robert said he could never seem to satisfy his father, who was constantly pushing him to go out for sports, to get better grades, to become an attorney. Because his father alternated between being very lenient with him to being extremely strict, he never really knew where he stood with him. Communications between father and son were blocked. Robert's father had once attempted to tell him about the facts of life, but became very uncomfortable and consequently did not get very far in the discussion. But he was furious when he learned that Robert had been involved in sexual relations with Barbara.

Robert said he had engaged in sexual relations with Barbara because his friends were having sexual experiences, and he could see nothing wrong with this and no reason why he should not. Although he and Barbara had had such relations over a period of time, the experiences had been unsatisfactory for him and had left him feeling depressed. After his first sexual experience, he felt so badly that he went to his church to seek the youth counselor in order to talk with him about his feelings. The youth counselor was not available and Robert did not pursue this further. He had known about contraceptives and had made some efforts to use them, but had abandoned their use because he did not like the idea, and so took no precautions to prevent pregnancy.

Robert said he had never entertained the idea of marriage during his relationship with Barbara. When he learned that she was pregnant, he had thought briefly of this possibility and quickly dismissed it. He said he was not ready for marriage nor did he feel that if he were that he would want to marry Barbara. His plans were to finish high school and go into the Navy where he could attend a technical school. He felt that marriage at this point would be wrong for him and therefore wrong for Barbara.

Robert found it difficult to believe that he was going to be a father. As the responsibilities involved in fatherhood were discussed with him, the implication of his involvement with Barbara became more meaningful and the realization that he was neither ready for marriage nor for fatherhood became very clear to him. He readily accepted the idea of adoption as a resolution for the predicament he found himself in—a solution accepted more gradually and painfully by Barbara.

The caseworker saw Robert as a confused adolescent who was seeking a security and acceptance in his relationship with Barbara that he did not get from his own family. In engaging in sexual relations, he was attempting to act in an adult manner, having no awareness nor preparation for the responsibilities involved. Counseling helped Robert to clarify some of his own feelings toward Barbara and toward himself as well as his future aspirations. He looked to his caseworker for guidance as well as help in better understanding himself.

Robert's parents kept all appointments set up for them. When the full implications of the trouble their son was in hit home, they became even more concerned than Robert about his predicament. But they were able to go beyond this to a concern about their own family interrelationships and their effects on Robert. In the agency they found a vehicle through which they were able to reach a better understanding of each other. This was particularly true for Robert and his father. Robert's father began to see his son as a person to whom he could be close without having to push him in directions that were not realistic for him.

Throughout, the caseworkers for the boy and his family and the girl and her family worked in a close team relationship through periodic conferences. Because the relationship between Barbara's and Robert's families was extremely strained, it was decided there should be no contact between them, except through the caseworkers. Barbara seemed relieved at this separation from Robert, although his continuing to come to the agency was of tremendous importance to her since it represented his continued interest.

The Sexual Experience

The overwhelming majority of teenage boys seen at Vista Del Mar seem to have had some perfunctory, technical information about sex before going into a sexual relationship. Some of this information was received in school, some from parents or from literature made available by parents, and some from their friends. While the vast majority of these boys have known about contraceptives, they have seldom used them when having sexual relations. A typical response when the social worker brings up the subject is: "Yes, I know all about this, but to have used a contraceptive would have been just having sex for sex's sake and our relationship had more meaning than that," or "She just wasn't that kind of girl." When asked why he engaged in sexual relations, a boy is apt to answer: "Some of my best friends at school have been doing this, so why shouldn't I?" or "Why not?" or "I don't see anything particularly wrong with this."

Some of the teenage couples seen by the agency had had only one or two sexual experiences with each other before the girl became pregnant. Others had been having relations for a period of months, and a few for as long as a year. When asked by the social worker, "What did your sexual experiences mean?" most of the boys have responded, like Robert, "To tell you the truth it was a very disappointing experience." But they were not able to admit to their friends that the experience had been disappointing, unsatisfactory, and depressing. One boy said to the social worker, "I hope that this is not what sexual relations in a marriage are like, because it just wasn't what I thought it was going to be." Another asked, "Will I be able to make a satisfactory adjustment in a marriage?" And another commented, "If that's all there is to it, I don't think it is really worth it."

Work With the Boy

In each case the social worker carefully discusses with the boy the implications of his attitude toward sex. He answers their questions, but takes a firm position with them about their responsibility for their acts and in no way condones their sexual behavior. He points out to them the reasons why they should not engage in premarital intercourse, discussing the differences between teenage love and a more mature and genuine relationship between people ready to meet the problems and responsibilities of adulthood together. He particularly stresses the responsibilities that go with parenthood and their basis in the need of every child for a stable and secure home.

The social worker points out not only the obvious risks of engaging in premarital intercourse, such as acquiring a venereal disease or impregnating a girl—dangers that most of the boys are well aware of—but also the risk of impairing later sexual adjustment in marriage. Most of the boys seem genuinely concerned about achieving a good marital relationship in later life.

When the responsibilities associated with fatherhood are discussed with these teenage boys, the overwhelming implication of what they are involved in suddenly seems to dawn on them. Occasionally a boy is seen who has not previously been told of the pregnancy or who, while well aware of the girl's problem, has not emotionally received the message that he is about to become a father.

"Me, a father!" said one 15-year-old boy. "You're kidding." Others have said over and over, "I just can't believe it."

At Vista Del Mar teenage fathers are usually given the opportunity to see their babies either at the hospital or at the agency. They react with both disbelief and concern: "Did I really produce that?" "I can't believe it's real." "Is it getting good care?"

Many of the boys stare at their baby as though transfixed. One boy became disturbed because his baby had a facial rash and insisted on calling this to the attention of the nurse. Another wanted to hold and fondle his baby.

Having seen his baby makes the boy sharply aware of the reality of the problems resulting from his sexual behavior. The responsibilities involved suddenly hit him with tremendous impact. Frequently he asks for assurance that the baby will receive the best possible care. The discussion of his future aspirations, the meaning of his relationship with the girl, marriage, and the alternatives possible in planning for the baby from then on take on greater meaning for him.

Work With Parents

The experiences at Vista Del Mar have shown that the parents of unwed teenagers involved in a pregnancy recognize the tremendous implications of the fact that a child is to be born out of wedlock, and realize that they are faced with a most serious problem requiring immediate attention. Recognizing their need for help, the agency actively extends its services to both the girl and the boy. In this process, the parents are encouraged to state clearly what they will or will not be able to do to help the teenagers.

For example, they are encouraged to say how much money they will spend in providing medical care and living arrangements for the girl and her child, how much support they would give the young couple in the case of marriage, and, finally, whether they would want to or be able to take the child into their home and raise it themselves. The agency takes the stand that the parents have a responsibility and a right to assert themselves in these respects. A clarification of this kind with the parents of both the boy and the girl can accomplish the following: It helps the parents take a definite position without excessive feelings of guilt; it helps the teenagers learn what their parents are feeling and what they are prepared to give; and it helps the social worker further define for the teenagers the reality which they must face.

Little "assertiveness" is needed on the part of the caseworker to involve the girl's parents in the service, for they usually come in with the girl or shortly thereafter on their own accord. However, the boy's parents—who are generally contacted shortly after the first interview with the boy—often meet the suggestion of service—either for themselves or the boy—with considerable resistance. Ways are usually found, however, to help them see their own and their boy's need for such a service. They are told in their beginning contacts with the agency that alternative solutions will be examined, that the agency is not going to force a preconceived solution upon them, but that an effort will be made to work out a satisfactory social solution without the authoritative use of the court. The seriousness of the situation is stressed not only in relation to the girl, which they readily comprehend, but also as it affects their son.

The Older Unmarried Father

A logical extension of working with teenage unwed parents and their families is to offer this service to older unmarried fathers. Agencies which have done so have found in many unmarried fathers a constellation of personal problems that are often deep seated and of long duration: an underlying fear of marriage and the responsibilities of fatherhood; a loss of confidence in their masculinity resulting in a need to prove its existence; a realization that the illicit relationship can have no permanency and no real direction and therefore offers no security.[7]

Contrary to general expectations, at Vista Del Mar we have found the older unmarried father to be as accessible and amenable, if not more so, than the teenage unmarried father. This is due in part to the fact that the older unmarried father is generally more aware than the teenager of the serious implications of an out-of-wedlock pregnancy. The fact that someone is genuinely interested in helping him grapple with some of his feelings and find a constructive way to meet the problem in which he has played a major role has opened the door to his participation in working toward its resolution.

Drawing the older unmarried father into participation in the agency's service begins with helping the girl to involve the man in the agency's efforts on

Involving the unwed father in casework service, as shown here, and giving him the help thought essential for unwed mothers may benefit the father and ease planning for mother and child.

their behalf. Recognizing the usual ambivalence in the attitude of each to the other, the caseworker utilizes the positive aspects of the relationship as an aid to this goal. However, the worker must be prepared for the fact that the girl may speak disparagingly of the father, since this is the image of him she expects society to have. Unfortunately, caseworkers often do not move beyond this point and fail to recognize that the girl may have positive as well as negative feelings toward the father of her unborn child. When the worker recognizes these positive feelings, the girl experiences the relief of being understood, rather than having to maintain a pretense of a "hatred" toward the man that she usually does not feel. The worker can then help the girl see the entire relationship more honestly, thus enabling her to examine her own part in the creation of the problem.

In the inital interview with the father, the social worker suggests that facing the situation represents a healthier, more mature approach than running from it. Ways of doing this are spelled out: standing by the girl, thus giving some dignity to the relationship; participating in the planning for the child; giving financial help; examining life's problems revealed by the predicament; and recognizing the meaning and responsibilities of fatherhood. When the work with the unmarried father is handled in this way, the man usually ceases to be defensive and constructive participation on his part begins. For example, John, a 31-year-old unmarried man who was about to flee the city when his 26-year-old companion became pregnant, responded to the male social worker's phone call by coming to the agency immediately. Because he feared a marriage for which he was in no way prepared, initially he saw flight as his only solution. His panic was alleviated by the suggestion of possible alternatives. He no longer had to run.

The married man who has a child by a woman other than his wife has serious problems to cope with relating to his marriage as well as to his concept of himself. Among the many questions that he must face are: Shall he tell his wife? How shall the child be provided for if the mother keeps the child? What will his relationship to the child be? What will the child's relationship be to the father's legal family? What will be the interactions between the different family units?

Occasionally assertive approaches have been necessary to bring putative fathers into the agency for discussions, but these have been found to be successful without recourse to the authority of the court. For example, repeated persuasive phone calls and letters have been used. If necessary, the caseworker offers an evening, noon, or Saturday appointment to facilitate and encourage an interview with the father. References to the possible legal, financial, and psychological consequences of the putative father's actions are used as tools to involve him in a service on his behalf.

Conclusion

Such work with unmarried fathers has revealed that they have considerably more feelings about their illegitimate offsprings and the mothers of these children than has heretofore been recognized. Moreover, the fact that the California State Department of Social Welfare is advising agencies to be cognizant of the rights of the unmarried father in relation to his child suggests that the claims made in courts for out-of-wedlock children by their fathers are significant. If the child of an unmarried father is not released for adoption, the father's rights need to be clarified. The place of the child in the father's life has to be given consideration as well as the financial arrangements he should make on behalf of the child.

Public assistance agencies especially need to work out a better understanding of the mechanisms and theory of support of illegitimate children by their fathers and the relationship of law enforcement to this problem. A climate of services must be an integral part of the approach.

An experiment in working with the unmarried father in a public assistance agency is underway at the Kern County Department of Welfare in Bakersfield, Calif., with special consultation from the Vista Del Mar Child-Care Service. There two caseworkers, one a man and the other a woman, are carrying a protected caseload of unmarried parents, including the fathers, all from economically deprived families. The results of this experiment will tell us much about unmarried fathers.

Research studies on fathers of illegitimate children should, on the whole, parallel studies being done on unmarried mothers. Further, such studies might test the validity of including the putative father in a structured casework service, by trying to determine:

1. The extent to which the putative father is available for casework interviews.

2. The effect that his being involved in a casework relationship has upon the unwed girl and upon himself.

3. The extent to which he will contribute financially to the expenses incurred.

4. The effect such service has upon decision-making regarding the future of the child.

5. The extent to which the methods used by a private agency can be applied by public agencies working primarily with the socially and economically underprivileged clients.

6. A profile of the putative father indicating who the putative fathers are, what they are like, what kind of problems they have.

With such knowledge it will become incumbent upon agencies to offer services to unmarried fathers similar in quality to those now available to unwed mothers.

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[1] Morlock, Maud: The fathers of children born out of wedlock. U.S. Department of Labor, Children's Bureau. 1939. (Reproduced by the U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau.) 1962.

[2] Choate, Reba E.; Gallagher, Ursula M.: Unmarried parents; a guide for the development of services in public welfare. U.S. Department of Health, Education, and Welfare, Social Security Administration, Bureau of Public Assistance and the Children's Bureau. BPA Report No. 45 and CB Publication No. 390. 1961.

[3] Child Welfare League of America: Child Welfare League of America standards for services to unmarried parents. New York. 1960.

[4] Vincent, Clark E.: Unmarried mothers. The Free Press of Glencoe, New York. 1961.

[5] Rowan, Matille; Pannor, Reuben: Work with teenage unwed parents and their families. *Child Welfare,* December 1959.

[6] Sister Ann: Counseling the unmarried father. Florence Crittenton Association of America, Chicago. 1959. (Processed.)

[7] Rowan, Matille; Pannor, Reuben: An assertive casework approach to the older unmarried father. *Child Welfare,* March 1961.

This is a moment when the answer to any question is likely to lie in a committee report or else the magic word "research." At the risk of announcing some premature findings, without benefit of committee or prolonged research, I venture to suggest that some of the major factors behind family problems are already well known. They include inadequate schools; crowded living conditions; ill health, physical and mental; poverty; the steady pressures, humiliations, and hostilities under which racial and ethnic minorities live; the influence of a culture which makes much of technique and little of ideas and purposes; and not least, the unresolved paradoxes of a moral outlook which at one and the same time connects sex with sin, uses sex to sell its products, and teaches its young to regard a strong attraction for a person of the opposite sex as something quasi-supernatural which can conquer all and excuse all. Something has to give, and what gives, in most cases, is the individual's belief that he has been taught any standards by which he can live.

Dr. Charles Frankel, professor of philosophy, Columbia University, to the 1962 forum of the National Conference on Social Welfare.

THE COMMUNITY'S PART IN PREVENTING ILLEGITIMACY

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THE PROBLEM of illegitimacy stems from complex personal and sociocultural factors. It involves young and middle-aged men and women, intelligent and mentally deficient, educated and uneducated, white and nonwhite, rich and poor. Therefore, coping effectively with this problem requires a broad range of treatment approaches and of community services which take into account its many aspects and their relation to individual and social adjustment. The community has a responsibility not only to help those involved in the problem but also to move toward prevention of unmarried parenthood within this broad and dynamic framework.

Acceptance of this responsibility implies the examination of certain key sociocultural factors associated with illegitimacy. They include poverty, migration, urbanization, lack of education, weak or ambivalently held moral standards, faulty parent-child relationships, social and emotional deprivation, and emotional disturbance or immaturity.

Recently, there has been increasing awareness of the possible relationship of the conflicts, ambiguities, and discontinuities in our social mores to the increase in illegitimacy. For example, a growing acceptance in the population as a whole of the naturalness of sex as a basic human drive is reflected in a seeming preoccupation with sex in the media of communication and in advertising. There seems to be widespread tolerance of extramarital sexual intercourse—as long as there is no baby. Then, the tendency to censure sexual behavior only when there are visible manifestations, and then only to censure one-half of the offending couple—the woman—furthers the uncertainty and confusion in relation to society's standards.

The emphasis on material success and what Vincent [1] calls "fun morality," and the tensions and uncertainty in the world intensify the problems of adolescents who are struggling to achieve a sense of self and to incorporate society's values.[2-4] Any effort to prevent illegitimacy among adolescents therefore must also take into account the exacerbation of personality problems during this period, and the normal struggle of adolescents to delineate and become identified with their social milieu.

Socioeconomic Class Factors

There have been attempts to apply cultural and historical concepts to the understanding of the disproportionately high incidence of illegitimacy among Negroes. These efforts have not to date substantially contributed to efforts to prevent this problem, for they have not expanded knowledge in a systematic, scientific manner. They have failed to cope with problems arising from the incompleteness of knowledge about what is cultural, reliance on "folklore," and the effects on the concepts of the values and prejudices of the research workers themselves. They have instead led to the use of generalizations, stereotypes, and questionable assumptions in a rigid, restrictive way.

This has been particularly true in regard to attempts to understand family structure and family life among Negro families of low socioeconomic status and their attitudes about illegitimacy. High illegitimacy rates among Negroes have often been explained as a carryover from the matriarchal family pattern which was maintained by the system of slavery. New insights into the variables affecting the styles of Negro life focus attention on the probable impact of urbanization, acculturation to the dominant group, upward mobility, and the cumulative effects of social and economic deprivation upon individual adjustment and patterns of family life. Study of such factors could provide a framework within which the variations and inconsistencies could be systematically considered. The family—its significance and functions in American society—is a complex phenomenon among low-income Negroes as well as among middle-class whites.

It is often maintained that among Negroes of the lower socioeconomic class, illegitimacy is accepted, moral laxness exists, and the prevailing standards of society are not accepted. The work of Davis,[5] Swanson and Miller,[6] Sister Woods,[7] and others on the implications of social class for child rearing point up the conflicts and confusion in goals and values among many sectors of the American community. The study of the cumulative effects of economic and social deprivation and the isolation and alienation of members of a minority group from the dominant society would seem to be a prerequisite for an objective, systematic inquiry into the salient attitudes, values, and behavior among Negroes of the lower socioeconomic class and their relationship to the high incidence of illegitimacy in this group.

Hylan Lewis, as a result of studying a group of low-income families, has observed that no single or simple value or attitude seemed to be operative in instances of birth out of wedlock: "Birth in wedlock is an important value; it might be preempted by another important value, or its realization thwarted by practical considerations. . . ."[8]

Role theory, theories relating to anomie and a delinquent subculture, and small group theory can help to broaden and deepen our understanding of the variations within a culture, but Negro culture, as Myrdal stated, "must be seen as basically American."[9] Since society has tended systematically to relegate the Negro to the lowest status in the community, the preponderance of social problems among Negroes can be seen as a "distorted development and as a pathological condition of the general American culture."[9]

Bases for Prevention

By devoting systematic attention to the sociocultural milieu and the implications of group membership, ethnic background, family roles, child-rearing patterns, life goals and attitudes, and the social sources of strain and pressure, a basis for preventive approaches can be elaborated. Nevertheless, no matter how complete the sociocultural understanding, the individual component remains to be coped with, for, as Viola Bernard has pointed out, the meaning of the experience of unmarried motherhood, causes leading up to it, and reactions to it differ so widely among the women who are involved "that individualizing is essential in any approach to the needs of this group."[10]

No one drastic action is likely to mitigate a problem as complex as unmarried parenthood. Community efforts toward prevention, to be effective, must be directed toward the broad social, economic, moral, and psychological problems of which illegitimacy may be a symptom. These efforts are most likely to succeed if developed within the framework of a sound health and welfare program focused on the strengthening of family life and concerned with social action to assure such basic necessities as adequate housing, education, and job and social opportunities for all. The provision of adequate social services to unmarried parents and their children is also an important preventive effort. Repetitive patterns of illegitimacy from generation to generation among families—as among some Negro families—may well be a reflection of the community's failure to provide casework and other services to the mothers at the time of their first pregnancies and adoptive and other resources for their children. A concerned, representative community leadership is, of course, a prerequisite for an effective attack on the problem.

Services for Unmarried Parents

Since the provision of adequate services for unmarried parents is essential to the prevention of further illegitimacy, a good start in the development of a preventive program would be the outlining of a clear statement of the community's specific responsibilities in relation to unmarried mothers and their children and a look at this in regard to what the community is providing.[11] This statement would be concerned not only with specific services but also with the legal structure under which they are provided—laws relating to eligibility for services, the care and protection of children, standards for licensing facilities, school attendance, and the like. The statement would of course be concerned with the range, nature, and quality of the direct services needed by unmarried mothers and their children, as well as by unmarried fathers.

Equally basic are the structure and relationships of the services. A sound structure makes it possible for an unmarried parent to be served in terms of her needs rather than in terms of the limits of agency function and the hazards of intake policies. It also provides for casefinding. Unmarried parents in particular are often deterred from using needed resources because their feelings about pregnancy may intensify their customary reluctance to seek help.

Community Participation

A broad program of prevention to be effective must include the participation of all sectors of the community—the professional including legal, religious, and school personnel, as well as social workers, doctors, and nurses—representatives of community organizations and parents and teenagers. Its form may vary, according to community needs, from collaboration on specific projects to formal organizational relationships. In any event, its activities should proceed from a common understanding of the objectives of health and welfare services in general and of the services specifically designed for unmarried parents; and on the basis of accurate information about the extent and nature of the needs, the effectiveness of existing services in meeting the needs, the gaps in services, and projections for the expansion of services. Its functioning will require a free and reciprocal flow of communication within both the professional and lay communities, and across all sections of the community; and the development or identification of a mechanism to assume leadership in interpreting the program to the community; to settle questions of social and professional policies; and to move toward the improvement of the community's health, welfare, educational, and employment services, the establishment of new services, the coordination of services, and the assessment of programs in relation to changing needs.

Because of the difficulties faced by unmarried parents and their children, the persistence of moral, subjective, and punitive attitudes toward them, and the tendency to look for single causes and simple solutions, it is not easy to establish a common approach to the problem of illegitimacy. The initiators of a preventive program, therefore, need to develop techniques which can bring those whose concern stems from various points of view and positions into a common frame of reference. While fragmented approaches can lead to dead ends, progress to an overall goal cannot be pushed without the growth of understanding. Many people can grow in their understanding of the difficulties faced by unmarried parents and the interrelationships between their problems and the broader health and welfare problems of the community by participation in one phase of the program. Others will need time to work out the irrational feelings and prejudices which tend to limit their understanding. The broadening of knowledge through factfinding as well as the broadening of experience through participation in a community program may be more effective in modifying attitudes than lectures and debates.

The taxpayer will learn the value of spending his dollar on prevention if he is given conclusive evidence that pennypinching in the long run is costly. He may also learn that casefinding of persons in difficulties is not stirring up "unnecessary trouble," or undermining the concept of self-dependence and individual motivation, but, rather, an economical, constructive aspect of sound community planning. Staffs and boards of established services may also have to learn to evaluate their activities in relation to the changing dimensions of the problem. Professional and lay people alike may need to do some rethinking and retooling.

A Suburban Example

For example, in a middle-class suburb of a large city a newly assigned high school counselor was struck by the lack of opportunity to discuss the problems of young people with representatives of the appropriate community organizations. The leaders of the community, proud of its high standard of living and wide range of community facilities, assumed that the needs of its youth were being met adequately and denied the existence of any problems. However, the counselor learned through the public health nurse that 14 girls out of 200 in the senior class had left school before graduation due to out-of-wedlock pregnancy. In all but two cases, the families had moved "for business reasons" to another community, or a hasty marriage had taken place, with the young couple moving elsewhere.

Such obvious and "easy" solutions very often create additional problems. A teenage unmarried mother might well find it almost impossible to resolve the burdensome guilt feelings about being responsible for the disruption of her family's life, and the resultant strain and tension could interfere with her educational and social adjustment. There is evidence that hasty, and especially "forced," teenage marriages are not stable and frequently end in divorce. Casework agencies have found that young unmarried mothers who have surrendered their babies for adoption unwillingly often have difficulties in their later personal adjustment and relationships. In this community the school guidance counselor is continuing in her efforts to persuade the community to develop the flexible, coordinated services to help meet this still "hidden" problem. These would include a program of family life education, a family counseling service, and specialized services for the unmarried mother and her child.

In some communities the fear of loss of function and status on the part of some agencies may block thoughtful study of community needs.

Difficulties in establishing interprofessional collaboration also often have to be dealt with. The traditional hierarchy of professional status and state of professional knowledge are some of the factors that contribute to the problem. Because of the importance of the first contact with the unmarried mother, no matter what type of agency or profession she first turns to for help, interprofessional, interagency collaboration must be developed.

There are many forms that such collaboration can take. One is the inclusion of physicians, attorneys, clergymen, and school personnel on statewide advisory committees to the public welfare agencies. In many communities across the country, councils of social agencies have assumed leadership in this direction through the establishment of interprofessional committees on unmarried mothers and on adoption and through the sponsorship of interprofessional conferences and research. The committees, however, are necessarily concerned with secondary prevention—services to unmarried mothers—rather than with the broader, more elusive problem of primary prevention.

A Case Study in Prevention

A creative aproach to the primary prevention of illegitimacy took place in New York City's Harlem last year as a demonstration project under the leadership of the Community Services Committee of the Urban League of Greater New York. Conceived as a method of helping teenagers and their parents understand the "facts of life," the program was based on the premise that unmarried parenthood is not an ethnic problem nor a question of immorality, but a reflection of basic defects and inequalities in community living. Harlem is an area of widespread health and welfare problems and inadequacy of services—in regard to both quality and quantity. Serious problems in the personality development and social adjustment of youth are reflected in learning difficulties, high school dropout rates, socially destructive behavior, and a high rate of illegitimacy.

The Community Services Committee, composed of professional and lay leaders, was established in 1958 as a result of informal discussions of the illegitimacy problem and the need for additional adoptive resources. Its members included two principals from neighborhood junior high schools, a clergyman, an attorney, two physicians, an administrator of the local public assistance office, a medical social worker from the public health department, a psychiatric social worker from the public mental health agency, a hospital social service director, a dentist, a nurse, a number of social workers from voluntary agencies, parents, and several young people. The group decided to focus on an area within a 10-block radius of the Urban League office.

A "family institute" was planned on the theme. "Problems of Urban Life." Four open sessions were held on consecutive Sunday evenings in a local church. In addition, members of the committee met with the editor of a local newspaper and planned a series of articles on Harlem family life for the paper. The committee members produced articles on the home, school, recreation, family activities, health maintenance, mental health, working mothers, religion in the family, and child care.

The committee next decided to focus on social-sex education for preteen and teenaged young people. The basic assumptions were that ignorance of life on the part of teenagers and their parents thwarts development of a stable family life, and that the lack of sex information on the part of teenagers and the reluctance of parents and other adults to discuss sex with them were contributing factors in illegitimacy.

The program was planned *with* the help of the young people themselves. The principals and guidance counselors of the junior high schools (each with 1,500 pupils) asked the students to put what questions they had about relations between the sexes into a question box in the school without signing their names. The questions received ranged from normal adolescent worries about boy-girl relationships, such as how to overcome shyness, to questions involving such serious problems as how to cope with the possibilities of rape, homosexual advances, and incest. Other questions were: "Why do adults think it is bad for teenagers to have intercourse?" "Why are there so many pregnancies among teenagers in our community?" and "Why do older men bother young girls?"

On the basis of the student's questions, an all-day "Facts of Life Conference" was planned. Individual invitations, with a R.S.V.P. form attached, were extended to students selected by the school guidance counselors and also to their parents. A "come-on" was a free lunch for all participants, provided for by members of a Masonic lodge.

The conference, which was held on a Saturday in the local Masonic temple, was attended by 120 girls, 60 boys, and 70 parents. It began with the showing of a film, "Social-Sex Attitudes in Adolescence," which was followed by discussion led by a skilled group leader. Then a panel consisting of a physician, a psychologist, a minister, a parent, and a teenager commented on the questions which had been submitted by the young people. After the panel discussion, the conferees were assigned to "buzz groups" of 10 each, the boys and girls in separate groups. Sixty volunteers from social agencies and other community services, who had participated in a training session prepared by the committee, served as leaders of the group discussions. A doctor, an attorney, and a family counselor served as technical consultants to the groups. The arrangements allowed for anyone wishing to make an appointment with an agency to do so in privacy.

The conference planning committee included representatives of a wide variety of local groups, assisted by the Urban League staff. Pertinent literature, obtained from business firms, health and welfare agencies, and insurance companies, was distributed. Radio, press, and television coverage was excellent, and conference participants later appeared on local radio programs.

After the conference the Community Services Committee met frequently to relate its ongoing program to the needs which the parents and teenagers had expressed. There were three subsequent conferences the next year, each incorporating some of the main features of the first. Meaningful contacts were established and maintained with previously unreached parents and teenagers.

Followup activities included a meeting with representatives of local social agencies and the preparation of a report—"Gaps in Services—Your Agency's Role." The Protestant Council and the Center for Human Relations of New York University acceded to a request from the committee to study social service needs in Harlem. The board of education has approved the proposal for increased guidance and social service staffs in each of the junior high schools which were part of this program, but staff has not yet been assigned.

How can we measure the manifold implications of such a program? The answer is that we cannot. Nevertheless, it is hard to believe that this program has not been a positive force in the lives of at least some of the individuals it has touched. It is, of course, only a fraction of the effort needed to improve the chances for a good quality of life for the young people of an area notorious for its overcrowding, lack of opportunities, and inadequacy of services.

Any vital program to prevent illegitimacy necessarily goes beyond the form and content of the usual community services, and draws in the interest and participation of every section of the community, including its young people and their parents. The fear of focusing on a subject which often arouses indignation and vindictiveness must give way to the salient issues involved. These will vary in kind and degree with different communities, thus requiring differences of emphasis in the formula of attack. But any formula must include at least some measure of the same basic ingredients: a program of family life education to reach parents as well as youth; social action to improve living conditions and opportunities in the community; and the closing of all gaps in the community's social and health services.

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[1] Vincent, Clark E.: Unmarried mothers. The Free Press of Glencoe, New York. 1961.

[2] Alpenfels, Esther J.: Values, goals of youth in our culture; their impact on the problem of illegitimacy among adolescents. Paper delivered at the National Conference on Social Welfare, 1962.

[3] Boehm, Werner W.: Social-cultural factors in adolescent unmarried motherhood. *In* Casework papers, 1961. Family Service Association of America, New York. 1961.

[4] Francis, Jean: Pressures and influences on youth as seen by a high school guidance director. National Association on Service to Unmarried Parents, New York. 1957.

[5] Davis, A.; Havighurst, R. J.: Social class and color differences in child rearing. *American Sociological Review*, November 1948.

[6] Miller, Daniel R.: Swanson, Guy E.: The changing American parent. John Wiley & Sons, New York. 1958.

[7] Woods, Sister Jerome M.: Cultural conditioning and mental health. *Social Casework*, June 1958.

[8] Lewis, Hylan: Child-rearing practices among low-income families in the District of Columbia. (Mimeographed progress report.) 1961.

[9] Myrdal, Gunnar: An American dilemma. Harper & Bros., New York. 1944.

[10] Bernard, Viola W.: Needs of unmarried parents and their children as seen by a psychiatrist. Paper delivered at the National Conference of Social Work, 1948.

[11] Choate, Reba E.; Gallagher, Ursula M.: Unmarried parents; a guide for the development of services in public welfare. U.S. Department of Health, Education, and Welfare, Social Security Administration, Bureau of Public Assistance and the Children's Bureau. BPA Report No. 45 and CB Publication No. 390. 1961.

BOOK NOTES

THE GROWING YEARS—ADOLESCENCE: a forward look at meeting the health, physical education, and recreation needs of adolescent boys and girls. Ann E. Jewett and Clyde Knapp, editors. American Association for Health, Physical Education, and Recreation. National Education Association, Washington, D.C. 1962. 320 pp. $5.

The 19 chapters of this volume present discussions of a broad variety of topics, including the physiology of adolescence, the socialization of youth, health and safety problems, the junior and senior high schools, vocational and nutritional guidance, sports and physical skills, education for leisure, and home and community centered recreation.

The majority of the discussions, written by specialists from the fields of health, education, and recreation, present an assessment of the various programs reviewed as well as brief analyses of the significant problem areas. In many chapters unmet needs are also delineated.

Chapter 19, "Future Programs," presents a series of 11 short statements by authorities and program innovators in the various fields, outlining some predictions and proposals concerning the future of American youth.

PLANNING AND OPERATING FACILITIES FOR CRIPPLED CHILDREN. W.B. Schoenbohm. Charles C Thomas, Springfield, Ill. 1962. 312 pp. $11.50.

Ramps with floors of nonskid, soft material, recessed hall fountains, and shower stalls equipped with chairs are part of the harvest of ideas offered in this manual that gives practical advice and information to those planning for and working with crippled children. Drawing on 24 years' experience with programs and facilities for such children, the author tries to anticipate the pitfalls, dilemmas, and needs confronting people in this work.

Five chapters each are devoted to three major types of facilities: the hospital-school giving care, education, and treatment; the nonresidential educational and treatment facility including special classrooms and public school units; and the residential camp. In a summary, the author, who is executive director of the Minnesota Society for Crippled Children and Adults, compares the developing of facilities and programs for handicapped children to "a thermometer which registers the degree of a people's concern for all of their children and their problems."

PROCEDURE AND EVIDENCE IN THE JUVENILE COURT. Advisory Council of Judges of the National Council on Crime and Delinquency, 44 East 23d Street, New York 10. 1962. 84 pp. $2.50.

Whether or not the "quantum of proof" for the community to take action against a child offender—through the juvenile courts—should be based on a "preponderance of evidence" or upon "clear, convincing proof" is among the issues pondered in this handbook for juvenile court judges and others whose work concerns juvenile or family courts.

After outlining basic principles of justice in the juvenile court as a blend of law and social work, the chapters turn to consideration of procedures, beginning with petition and notice to child and family, the legal aspects of the court hearing, the right to counsel, and the court's responsibility for providing it.

PSYCHOLOGICAL DIFFERENTIATION. Herman A. Witkin, Ruth B. Dyk, Hanna F. Faterson, Donald R. Goodenough, and Stephen A. Karp. John Wiley & Sons, New York. 1962. 418 pp. $7.95.

In their search for answers to the question of why individuals differ in the pace and direction of psychological growth, the authors, faculty members of the Department of Psychiatry of the State University of New York, College of Medicine, New York City, conducted a series of studies on children, which they report in this book. The investigators based their work on the theory that the child grows psychologically partly by progressing from the global, unarticulated way of experiencing that is characteristic of infants, towards being able, increasingly, to distinguish objects from their contexts or fields. The authors explain how this progress in differentiation, or towards "field-independence," helps strengthen a person's sense of self-identity and helps develop his controls and defenses; they also theorize that different people achieve various levels of differentiation, the level achieved in turn affecting the way the person approaches life.

The authors draw on their own and others' research to identify some common attributes of persons with field-dependent and of those with field-independent "styles of life"—finding the former more likely than the latter to change their opinions in line with those of authority, to excel in verbal skills, and to have difficulty in overcoming the influence of surroundings.

The first group of studies assay the validity and interrelationships of some "indicators" of differentiation level. The book also reports on studies seeking sources of individual differences in level of differentiation, within the individual's constitution and in his early life experiences.

SO YOU WANT TO BE A SOCIAL WORKER. Helen Harris Perlman. Harper & Bros., New York. 1962. 173 pp. $3.50.

This career explaining book opens with three dramatic narratives depicting a typical day's work of the social group worker in a neighborhood center, a social caseworker in a family service agency, and a community organizer on the staff of a welfare council.

The bulk of the book's seven chapters explains what social work is concerned with—"enabling people, singly or in groups, to work and love and live together in ways that build their sense of dignity and social responsibility"—the variety of social problems with which social workers deal; the methods common to all types of social work; and the types of agencies through which social workers function.

IN THE JOURNALS

Physician and Social Worker

In the January 1963 issue of *Social Work*, Morris A. Wessel, associate clinical professor of pediatrics at Yale University School of Medicine, calls for better communication and tolerance between physicians and social workers in their work with unmarried mothers. ("The Unmarried Mother: A Social Work-Medical Responsibility.") The author describes the expectations of a physician from a social worker to whom he referred an unmarried mother for social service, his confusion when social work practice demands that the worker act differently from the way a physician would, and his consternation when the patient after receiving social casework help changes her mind about adoption.

Commenting that the physician may be struggling with his own subjective attitudes and probably does not have the kind of specialized knowledge that makes his patient's behavior understandable to the social worker, the author advises social workers to empathize with their medical colleagues and give them a feeling of worth, as social workers are trained to do for their clients. The practice in some social agencies which serve unmarried mothers of adding pediatric, obstretric, and psychiatric consultants to their staffs can be a learning experience for social workers and physicians, he observes.

The Culturally Deprived

Schools in our highly urbanized society tend to perpetuate social class differences which inhibit learning opportunities among the children of underprivileged groups, charges Delmo Della-Dora, deputy superintendent of the Wayne County (Detroit) Board of Education, in *Exceptional Children* for January 1963. ("The Culturally Disadvantaged: Further Observations.") Citing evidence indicating that residential patterns in large cities and attitudes of middle-class teachers tend to isolate the socially deprived from opportunities for cultural stimulation, the author makes a number of suggestions for creating a more favorable atmosphere for learning among deprived groups.

He urges coordinated efforts for community improvement among all agencies affecting community life, direct teaching aimed at changing the negative self-concepts of deprived pupils and parents, and self-studies in the schools of the impact of social class differences on students and teachers. The schools, he maintains, should be among the agents of changes needed to improve the democratic quality of living.

Combined Care

Psychosocial problems predominate over medical problems among the patients in the welfare medical care project of the New York Hospital-Cornell Medical Center, according to observations of the project's social service coordinator and its director reported in January 1963 the *Social Casework*. ("Co-ordinated Medical Care for Public Welfare Clients: Implications for Medical Social Work Practice," by Margaret A. Dennis and Charles C. Goodrich.) The article discusses some social work aspects of the 5-year project begun in 1960 to demonstrate the provision through a voluntary hospital of comprehensive, continuous, and coordinated medical care to recipients of public assistance. With funds provided by the New York City Department of Health, the project offers such care to 1,000 families placed on the public assistance rolls at an east mid-Manhattan center of the New York City Department of Welfare during one year.

Through the medium of a case history, the article illustrates the kinds of human problems encountered in this type of project and how events precipitated by personnel changes or communication failures, for example, can heighten anxiety among patients who are on the relief rolls.

Among some questions the authors find raised by the project are: Should a hospital social service department become, in essence, a family agency for patients served in a comprehensive care program? Should a public welfare agency try to give family casework services to clients in a medical care program in which social work services are available? Should there be a public agency to provide comprehensive medical care services to low-income families? How can social services be provided best to former public welfare clients when they are no longer receiving financial assistance?

A Matter of Perspective

The concept of social values is the key to parental child-rearing practices, according to a sociologist on the staff of the National Institute of Mental Health writing in the January 1963 issue of the *American Journal of Sociology*. ("Social Class and Parent-Child Relationships: An Interpretation," by Melvin L. Kohn.) He contrasts some values of the middle class—white collar workers and professional people—with those of the "working class"—skilled and unskilled manual workers. For example, middle-class parents value curiosity, happiness, consideration, and self-control in their children; working class parents, obedience, neatness, and cleanliness.

To explain these differences, the author discusses the complex process of value formation, emphasizing the elusive influences within the conditions of life of each class. More stable, higher levels of income, he points out, allow middle-class parents to take respectability more for granted than can many working class parents, and hence to concentrate on feelings rather than actions. Among his other points is that middle-class occupations deal more with the manipulation of interpersonal relations than with things; and they often call for independent action. Therefore, the middle-class person must depend more on self-direction, while manual workers, who must follow explicit rules set down by someone else in authority, must build up a respect for authority. These differences, he suggests, explain why middle-class parents look for a child's intent and feelings about what he does, while working class parents are concerned more about the child's act.

Tracing some of the consequences of these value differences, the author notes that middle-class parents are generally more supportive of children and show less difference between roles of mother and father; working class parents are often more constraining, with the mother tending to be more supportive than the father.

Family-Centered Nursing

An attempt to evaluate the effectiveness of a family-centered public health nursing service is described in the January 1963 issue of *Nursing Outlook* by three staff members of the Community Service Society of New York ("Evaluating Public Health Nursing Service to the Maternity Patient and Her Family," by Ann W. Shyne, director of the society's Center for Social Casework Research; Aline F. LeMat, director of its public health nursing projects; and Leonard S. Kogan, director of its Institute of Welfare Research.)

Under the projects the continuous service was given in the home until 6 months after delivery to 80 patients who had registered for prenatal care at a large public hospital.

Evaluation was made on the basis of a followup interview conducted 6 months after delivery with the patient by a nurse previously unacquainted with the patient or her family. Similar followup interviews were held with patients who did not receive the specialized service.

The authors report that when before-and-after judgments of each family's health condition were compared, greater gains were found in three areas among the patients who received special services than among those in the control group. These were: (1) the general physical condition of the maternity patient herself; (2) her physical and psychological readiness for delivery; and (3) the family's nutritional practices. But they also report that the difference in improvement in health knowledge and practice between the two groups was not appreciable.

The authors maintain that the results of the project indicate "the desirability of a family-centered public health nursing service as a supplement to the usual community health services available to maternity patients."

Guides and Reports

CASEWORK WITH ADOLESCENTS: 50th Anniversary Institute on Adolescence, May 1961. Scholarship and Guidance Association, 205 West Wacker Drive, Chicago 6, Ill. 1962. 18 pp. $1.50 (mimeographed). (See p. 194.) Two additional papers on adolescence by association staff members, 25 cents each (mimeographed).

The institute proceedings contains three papers: "Character Disorders in Adolescents," by M. A. Sklansky, M.D.; "The Psychodynamics of the Initial Phases of Treatment With Adolescents," by Solomon O. Lichter; "Serious School Malfunctioning," by Elsie Rapien and Frances Seibert. The other papers consist of one on the character of the adolescent ego by Dr. Sklansky, and one by Dr. Sklansky and Dr. Lichter on impulse experience and control in adolescence.

SERVICES FOR CHILDREN WITH ORTHOPEDIC HANDICAPS: a guide for public health personnel. Committee on Child Health, American Public Health Association, 1790 Broadway, New York 19. 1962. 128 pp. $2.50. Less in quantity.

This 11th in a series of guides to the organization and administration of services for children with specific handicapping conditions is concerned with children having single types of orthopedic disabilities. Outlining the nature and causes of orthopedic conditions, it suggests methods of prevention, and discusses casefinding, rehabilitation, the provision of special services and facilities, and the organization of community resources.

PROTECTING THE BATTERED CHILD. Edgar J. Merrill, Irving Kaufman, Philip R. Dodge, and Arthur E. Schoepfer. Children's Division, The American Humane Association, 896 Pennsylvania Street, Denver 3, Colo. 1962. 30 pp. 35 cents.

Contains four papers presented at the 1962 National Conference on Social Welfare, discussing the problem of parental abuse of children from the viewpoint of social work, psychiatry, medicine, and the law. One of the papers reports on a 1960 statewide study of child abuse undertaken by a child protective agency, citing three case illustrations and disclosing identifiable characteristics and personality traits of the families involved.

THE PREPARATION AND THE ROLE OF NURSES IN SCHOOL HEALTH PROGRAMS; guidelines for the use of administrators, educators, and students. Helen Goodale Florentine. National League for Nursing, Department of Baccalaureate and Higher Degree Programs, 10 Columbus Circle, New York 19. 1962. 29 pp. $1.

The five areas chosen for exploration in this guide are: (1) the application of concepts of human growth, development, and behavior; (2) the prevention, detection, and treatment of students' developmental and health needs; (3) working with existing community agencies to spot gaps in needed services; (4) understanding the educational setting; and (5) the use of processes appropriate to the situation.

CRITERIA FOR THE DIFFERENTIAL USE OF TREATMENT SETTINGS FOR CHILDREN WITH EMOTIONAL DISORDERS. Child Welfare League of America, 44 East 23d Street, New York 10. 1962. 28 pp. 90 cents.

The monograph includes four papers by officials of various treatment and rehabilitative settings for emotionally disturbed children—a closed facility for children at a State hospital; a voluntary psychiatric hospital for children; an open-type residential treatment center; and a day treatment center. A summary points to the need for establishing a broad range of coordinated programs of services for mentally ill children as well as for expanding knowledge on treatability.

HERE AND THERE

For the World's Children

About 75 social work administrators, educators, and practitioners from the United States and Canada attended a seminar on "Planning for the World's Children" held at the United Nations in New York, January 17–18, to discuss the potentials of social work in current international efforts to improve the lot of children. The meeting was held under the auspices of the National Association of Social Workers and the Canadian Association of Social Workers, in cooperation with the United Nations Children's Fund (UNICEF).

Addresses by Maurice Pate, executive director of UNICEF, Zena Harman, chairman of the program committee of UNICEF's executive board, Julia Henderson, director of the United Nations Bureau of Social Affairs, and Fred Delli Quadri, U.S. representative to UNICEF, put the focus on the lessons being learned in UNICEF's own expanding social service program, especially on the need for what Mrs. Harman called "action-oriented rather than therapy-oriented social work" and for built-in flexibility. Miss Henderson stressed the importance of data on a country's economic and human resources in planning to help a country meet its social needs.

In four simultaneous work groups the seminar's participants discussed problems of international social work. Some points they emphasized:

- Social work programs can only be effective if governments are convinced that the welfare of children is inextricably tied up with raising the standard of living.
- The social worker in another country must look for strengths within the local culture and work within them rather than superimpose patterns derived from conditions elsewhere, and must "start with people at their starting point." This requires humility, flexibility, resourcefulness, and sensitivity to the bonds which have helped the local culture to survive.
- In helping a government appraise its social needs and develop a sound social policy, the social worker must be alert to the possibilities of developing new kinds of services, of using available resources such as volunteer groups, and of achieving support for protective legislation. Success requires "getting feet in the mud" in addition to writing reports to government officials.
- Among the familiar services that can cushion children and their families in developing countries from the impact of shattering social changes are: day care, family counseling, institutional care, homemaker services, vocational services for youth, and probation work.
- Help in the development of social work training is one of the major contributions that can be made through an international program.
- North American schools of social work can contribute to international social work by placing greater emphasis on the study of other cultures, and the provision of field experience in a variety of cultural settings, especially where resources are extremely limited. Also valuable would be periodic refresher courses for social workers employed abroad.

Throughout the discussion the participants called for more dedication by the profession of social work in North America to the application of its skills to meet the needs of children in other parts of the world. Out of such efforts, it was pointed out, could come enrichment of the profession through deepened understanding, broader perspective, and fresh ideas.

—ELEONORA CHATTY

Mental Health

The competing demands of service needs versus training needs in relation to child psychiatry received considerable attention at a conference on training in child psychiatry in Washington, D.C., January 10–15. Held under the auspices of the American Psychiatric Association and the American Academy of Child Psychiatry, with funds from the National Institute of Mental Health, Public Health Service, the conference was attended by approximately 60 psychiatrists. Chairmen for the conference were Drs. Reginald Lourie, representing the American Psychiatric Association, and Athilda Krug, for the American Academy of Child Psychiatry.

The discussions proceeded from a number of working papers covering four main topics: (1) history, development, and present status of training in child psychiatry; (2) training needs in relation to the actual functioning of child psychiatrists in a variety of settings; (3) the content of training in child psychiatry; and (4) methodology and setting for training in child psychiatry.

Understanding principles of child development was recognized as basic to the training of child psychiatrists, and some pediatric training as useful. Some participants expressed discouragement about the possibilities for primary prevention of mental and emotion illness in view of the paucity of knowledge of causes; others, however, urged that what is already known about prevention be applied while efforts to find out more are continued. There was agreement that more research in child psychiatry was needed.

Out of the discussions emerged the suggestion for a survey of mental illness among children similar to the study of the Joint Commission on Mental Illness and Health.

A volume of the conference proceedings, including the recommendations, is to be published in the near future by the American Psychiatric Association.

National Service Corps

On January 14, President Kennedy in his state of the Union message proposed the formation of a corps of volunteers along the lines of the Peace Corps for service to communities in this country. The proposal was based on recommendations made by the President's Study Group on National Voluntary Services in its report which was released to the public in late January.

The 11-member study group, composed of heads of Federal departments and independent agencies concerned with domestic affairs, with the Attorney General as chairman, was appointed late last year to gauge the feasibility of a national service program. It proposed that the President ask for congressional authority to create the service as an independent agency, with advisory assistance from public and private groups.

As described in the study group's report, the domestic volunteer corps would work in such places as mental hospitals, on Indian reservations, in understaffed schools, in centers for the aged, or in institutions for young delinquents. Its purpose would be to act as a fuse to set off powerful local attacks on local problems, releasing the "incalculable energy of volunteer service by motivating more and more people to give some of their time in the interest of human welfare."

While the report recognizes that volunteer service cannot solve the major problems of unmet human needs in this country and of severe shortages in the helping professions, it suggests that volunteers can "enrich the lives of culturally deprived families by helping them to become integral participants in community life," and enable professional persons to perform at optimum levels by releasing them from nonprofessional duties. Many young volunteers, it suggests, might by such service be influenced to choose a career in one of the undermanned fields of service.

The report recommends that the volunteers be at least 21 years of age, suggesting college students and retired persons as the most likely sources of recruitment. It suggests that the program be launched in midsummer, with 200 to 500 volunteers whose ranks would expand to 1,000 during the first year and to 5,000 in 3 years. According to its recommendations, volunteers would be selected according to Peace Corps standards, and be trained for specific jobs in schools, recreation programs, day care and other welfare services, and rural and urban renewal projects. They would serve 1 year, be allowed to re-enlist for another year, and would receive minimal living allowances and nominal termination pay. They would go where invited and be used under the direction of local leaders.

In its explorations the study group encountered many proposals for the use of corpsmen, five of which are described in its report. These include proposals to use volunteers: in the New York City public school system to work with underachieving and gifted children as well as with school dropouts; in Massachusetts as aids in institutions for the mentally ill and mentally retarded; in California to help extend a program of health, welfare, and educational services to migrant farm families; in Kentucky to work in adult education and town redevelopment projects; and in South Dakota to work with the Oglala Sioux tribe in community improvement projects on the Pine Ridge Reservation.

In his state of the Union message, the President also proposed the establishment of a youth conservation corps to be composed of young people between 16 and 21 years of age, which would have as its primary purpose providing young people who are out of school with constructive employment.

Infant Mortality

Among 10 of the Nation's cities with the largest number of live births in 1960, only one, Los Angeles, had a rate of infant deaths lower than the rate of 26 per 1,000 live births registered for the country as a whole in that year according to analyses by the Children's Bureau of data provided by the National Vital Statistics Division, Public Health Service. The data show that 5 years earlier 2 of these cities had infant mortality rates lower than the rate for the Nation as a whole—26.4 per 1,000 live births; and that in 1950, the rates of 8 of the cities were below the national infant mortality rate of 29.2 deaths per 1,000 live births. The cities included in the comparison in addition to Los Angeles were New York, Chicago, Philadelphia, Detroit, Baltimore, Cleveland, Houston, Washington, D.C., and St. Louis. In each of the 10 cities, the death rate was notably higher for nonwhite infants than for white, as it was for the Nation as a whole.

The 1960 infant death rate was slightly lower than the 26.4 rate for 1959, representing a saving of more than 1,500 babies. However, for the country as a whole, the rate for whites decreased 14.6 percent in the period 1950 to 1960—from 26.8 to 22.9—and for nonwhites only 2.9 percent, although the rates for nonwhite infants were much higher, 44.5 in 1950 and 43.2 in 1960. The infant mortality rate for metropolitan counties fell more slowly than that for nonmetropolitan counties, most of the improvement in the rate for both occurring during the first half of the decade.

The infant mortality rates in the individual States in 1960 range from the low of 19.6 for Utah to a high of 41.6 for Mississippi. The rate for the United States as a whole still ranks 10th from the lowest rate among countries of over 300,000 population, with reporting relatively complete and based on internationally accepted definitions. (See CHILDREN, September–October 1962, p. 201.)

Health Research

An institute to conduct research in aphasia in children was set up last fall at the Medical Center of Stanford University, with an initial grant of $22,200 from the Scottish Rite Foundation of California.

The center diagnoses and evaluates a limited number of children up to age 13, brought to the center because, in spite of otherwise normal intelligence, they have been unable to learn to speak or read and write. The evaluation, lasting 3 to 10 days, is carried out by a team of pediatrician, neurologist, and psychologist, and speech and hearing specialists. After screening, 10 to 15 preschool children whose condition has been determined to be the result of neurological difficulties were to be trained for 1 to 3 years.

The specific goals of the project include developing special techniques to teach aphasic children to speak and understand language and pinpointing the learning problems associated with brain injury. It will train teachers and speech therapists to work with aphasic children. It will also provide counseling and guidance for parents of children who cannot be accepted for training, referring them to other agencies.

Director of the project is Dr. Jon Eisenson, on leave as director of the speech clinic at Queens College, New York City. The new institute, to be known as the Scottish Rite Institute for Childhood Aphasia, was established under the auspices of the School of Medicine's Division of Speech Pathology and Audiology.

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A 7-year interdisciplinary project of research in cleft palate got underway last September at the University of Pittsburgh following a grant of $295,669 from the National Institute of Dental Research, Public Health Service, for the first year of operation. Amounts of grants for subsequent years will be determined later.

The project's research team, expected to total 20 members the first year, includes oral and plastic surgeons, orthodontists, prosthodontists, pedodontists, pediatricians, oral and speech pathologists, and a morphologist, an otologist, a social worker, a psychologist, and a psychiatrist. Project plans call for investigating the growth and development of oral structures; problems of impaired speech in cleft-palate children; surgical and dental rehabilitation; and mental and emotional development of children with cleft palates and the effects upon the family. Dr. Edward J. Forrest, Dean, School of Dentistry, is chairman of the administrative committee.

. . .

The isolation and identification of the virus that causes German measles were reported in late 1962 by Public Health Service scientists at the National Institute of Neurological Diseases and Blindness and the National Institute of Allergy and Infectious Diseases. The scientists isolated the virus from over 82 percent of a series of patients with rubella composed of Army recruits and children. Their investigations confirm and extend work carried out by the Walter Reed Army Institute of Research which in March 1962 reported isolation of the virus.

The Walter Reed studies had detected the virus in tissue culture by its blocking of another virus infection, findings which led to the development of a susceptibility test for German measles reported last fall. Independently and simultaneously, the same virus that was isolated at Walter Reed was uncovered in the laboratories of the Harvard School of Public Health. The virus when frozen remains viable for a year or more. It is resistant to a number of antibiotics.

The isolation and identification of the rubella virus, according to the National Institutes of Health investigators, represent a major stride toward development of a preventive vaccine sought especially to protect pregnant women from developing the disease. Studies have indicated that birth defects occur in some 50 percent of liveborn babies whose mothers had rubella during the first month of pregnancy and in about 20 percent of infants whose mothers had the disease during the first trimester.

Youth Employment

A four-pronged drive to cut the school dropout rate among District of Columbia youth was launched by the area's school system last fall, featuring orientation courses, vocational guidance, part-time work, and changes in curricula for slow learners.

In recognition of the high dropout rate between the end of junior high school and entrance into senior high school, one part of the program will focus on 150 junior high school students with learning problems or other problems of school adjustment, providing them with special services and training.

In addition to courses in the regular school curriculum and in remedial reading and arithmetic, the demonstration group's 80 seventh-graders receive vocational guidance, and training in good citizenship; the 40 eighth-graders, job conditioning; and the 30 ninth-graders, job training—in valet services, food handling and preparation, nursery school assistance, and laundry work—as well as job counseling and tours of job sites. Food training includes making breakfasts for children who arrive at school hungry. Parents of the group receive counseling, attend lectures, and visit job sites.

NEW WELFARE ADMINISTRATION

On January 28, the major welfare programs of the Department of Health, Education, and Welfare were brought under a newly established Welfare Administration. Dr. Ellen Winston, for 18 years commissioner of public welfare for North Carolina, was sworn in as the Federal Government's first Commissioner of Welfare and as such will head the new agency.

The Welfare Administration includes the Children's Bureau, the Bureau of Family Services, and the Cuban Refugee Program—all previously under the Social Security Administration. Its other components, which formerly reported directly to the Secretary of Health, Education, and Welfare, are the Department's Office of Aging (formerly the Special Staff on Aging), and the Office of Juvenile Delinquency and Youth Development (formerly the Office of the Special Assistant to the Secretary for Juvenile Delinquency). On the same date, the Office of Vocation Rehabilitation became the Vocational Rehabilitation Administration, with Mary Switzer, the former Director, as Commissioner.

Robert M. Ball, Commissioner of Social Security, continues as head of the Social Security Administration. The Office of the Commissioner of the Social Security Administration will absorb the staff and functions of the Director's office of the former Bureau of Old-Age and Survivors Insurance. The divisions of the former bureau will become divisions of the Social Security Administration and report directly to the Commissioner. Other units of SSA will be: the Bureau of Hearings and Appeals and the Bureau of Federal Credit Unions.

Dr. Ellen Winston

"Goals for this new Welfare Administration, dedicated as it is to preventive and rehabilitative services, must be clearly defined and stated again and again," said Dr. Winston at her swearing-in ceremony. "Success in their attainment will be measured by the opportunities given to children to rise above the handicaps of deprivation and neglect, to the disabled fully to utilize their capabilities, to the ill to receive needed treatment, to the aged in all walks of life to live without fear or loneliness, to families to obtain needed help and guidance in resolving a wide range of special problems, to untold numbers to be spared dire poverty and personal disaster through effective preventive measures."

Other features of the program include:

- Expanding to a second school—and to 20 more boys—a project begun last year in which 20 boys attended their high school class 4 hours a day—learning, among other things, custodial skills—and worked 4 hours a day at nearby schools at $1.32 an hour.
- Training 20 girls as cafeteria workers and short-order cooks, while they continue their academic studies, by placing them in part-time jobs in school cafeterias with pay of $1.10 an hour.
- Evaluating and revising English, mathematics, social studies, and science curriculum guides for slow learners and writing new guides in home economics, industrial arts, and personal and family living programs.

Financial help for the program has been extended by the Urban Service Corps, an organization set up within the District school system with private funds to help combat juvenile delinquency.

. . .

The San Francisco Unified School District and the city's housing authority have designed an antidropout program of work and study during school hours for high school juniors and seniors living in developments of the housing authority. The plan has the dual aim of helping potential dropouts recognize the need for further schooling in preparing for permanent employment and to help the student who wants to continue in school but is unable to for economic reasons.

Each of the trainees—30 in all initially but 100 a year eventually—will spend 4 hours of the schoolday in one of a variety of jobs in the housing authority, for which he will receive five credit hours per semester as well as $1.25 an hour.

The school system is also developing an orientation program for trainees that focuses attention to job skill development, including the need for such qualities as dependability on the job and work habits important to success. Employment and vocational counselors are expected to help trainees who complete the program to find full-time employment.

. . .

By January 25, more than 550 projects for training unemployed and underemployed persons in schools and colleges had been approved under the new Manpower Development and Training Act of 1962. (See CHILDREN, July–August 1962, p. 163.) The programs were designed to train a total of 20,596 persons. All together they will involve training costs of more than $10 million and almost $14 million in training allowances, subsistence, and transportation costs. The courses cover about 135 occupational categories and range in duration from 2 weeks to a year.

By last year's close, 291 courses had begun, with an enrollment of 6,315 persons of whom almost 1,500 had completed their training by December 31.

One-fourth of those who began training in 1962 were under 22 years of age. This is about the same proportion of youth as found among all unemployed workers in the Nation. The young trainees fell mainly in the 19–21 age category, which is the group eligible for youth training allowances of the act.

Young male trainees were enrolled in a variety of courses covering all major occupation groups and skills. Young women were being prepared for occupations in the clerical and sales fields.

Child Welfare

Among children served by child welfare agencies in 1961, children for whom neglect, abuse, or exploitation had been a major problem far outnumbered the others in all but six States, according to a nationwide study by the Children's Bureau in cooperation with the Child Welfare League of America. The study focused on the kinds of problems children served by such agencies had and the services these agencies were giving them. One purpose of the study was to test conclusions from a study carried out in 45 States during 1959, covering physical characteristics, location, public assistance status, and marital status of parents of children receiving child welfare services.

From samples representing more than 426,000—possibly over half a million—children under care of public agencies or voluntary member agencies in the league, the present study produced findings indicating that:

- Neglect, abuse, or exploitation ranked first as the major problem in public child welfare agencies, affecting 36 percent of the children; and ranked third in voluntary agencies, affecting 13 percent of the children.
- The most important single problem occasioning service to children by voluntary agencies was that their parents were not married to each other.
- Emotional or behavior difficulties ranked second for children of both voluntary and public agencies. Other problems encountered included conflicts in parent-child relations, illness of a parent, and unmarried parenthood on the part of the child.
- Financial need ranked first as a problem for 5 percent of the children in public agencies. More than half the children served for this reason were in Alabama, Mississippi, and Pennsylvania. In Mississippi, which has no statewide general assistance program, financial need was the primary problem in 40 percent of all cases served by child welfare agencies.
- Casework to children in foster care was the specific service given to the largest proportion of children as a principal service in both kinds of agencies. It was given to 30 percent of the children of public agencies and 28 percent of those of voluntary agencies.
- Children who had been placed in foster care four or more times comprised 16 percent of the children served by public child welfare agencies and 15 percent of the voluntary agency group; 2 percent of the former and 1 percent of the latter were placed more than eight times.

A complete report of the study will be available in the near future.

. . .

A project to test whether, by screening children with the severest behavior problems in the school population, a community can identify families with problems likely to lead to unacceptable behavior or dependency, or both, is planned to start in the late spring of 1963 under the sponsorship of the Child Study Association of America and the direction of Paul T. Beisser, formerly of Community Research Associates.

This approach to identification of disorganized families is being developed as an epidemiological technique contributing to preventive efforts in the field of social work. It is based on the findings of a pilot study made a year ago in San Mateo County, Calif., under the sponsorship of the County Board of Education. There, 2,872 children were scored by their teachers according to behavior rating scales. Results showed that, in a sample of 67 families identified by San Mateo's Coordination Bureau for Family Services as "recidivist, multiproblem families," 80 percent had children among those with the most severe school behavior problems. A report of the study, "Early Identification of Behavior Problem Children and Multi-Problem Families," is available from the office of the San Mateo County Superintendent of Schools.

The plans for the expanded project call for selecting a sample of about 100 of the most severe behavior cases in grades one through four in 10 communities and financing the services of a caseworker for diagnostic and followup work.

Miscellaneous

From the time the Freedom From Hunger Campaign was launched by the Food and Agriculture Organization in the summer of 1960 until November 1962, projects involving $20 million were adopted by various sponsors throughout the world. This worldwide educational program for agricultural development is designed to spread understanding of the problems and inadequacies of food supply, to improve production, and to combat malnutrition in the less developed countries, with emphasis on "self-help." About 100 projects were submitted to the organization during the 2-year period.

. . .

How the recommendations of the President's Panel on Mental Retardation (see CHILDREN, January–February 1963, page 29) can best be carried out, will be the subject of intensive consideration at a small conference to be held in Washington on April 9 under the auspices of the Citizens Committee for the 50th Anniversary of the Children's Bureau, thus rounding out a year of anniversary activities begun by the committee with an all day stocktaking celebration in Washington on the same date in 1962. (See CHILDREN, May–June 1962, page 120.) Besides the members of the committee, the coming conference will be attended by a group of experts in mental retardation and selected members of the Children's Bureau staff.

The proceedings of the conference will be reported in the May–June issue of CHILDREN.

. . .

"A Shirt a Size Too Small," a new play about a child in court pointing up the need for better court and community services, has recently been made available for production from the Plays for Living Committee of the Family Service Association of America.

For additional information write to Plays for Living, Family Service Association of America, 44 East 23d Street, New York 10.

READERS' EXCHANGE

OPPENHEIMER: *Group leader needed*

The article by Hannah Oppenheimer in the November–December 1962 issue of CHILDREN, "Case Conferences in a Family Center," highlights the role of the case conference for agencies dealing with the problems of children and families. However, I would like to raise some points which do not seem to have received enough emphasis.

The case conference atmosphere is portrayed in the article as "informal" with "all staff members participating." While this democratic approach is valuable in order to use the varied talents and skills of a trained staff, I find lacking mention of the role of leader or coordinator in the group. It has been my experience that case conferences bringing together persons with various levels of professional training and skill can precipitate sharp differences of opinion. In order to prevent such a group from becoming chaotic, a respected group leader is necessary.

At the Hennepin County Mental Health Center, the frequent interagency conferences concerning children are coordinated by the child psychiatrist, Dr. James Lawton. The participants—teachers, school social workers, physicians, psychologists, probation officers, welfare agency personnel—are encouraged to express their views freely. Surprisingly, the group leader frequently has to point out that the differences among conference members concern the *method* of dealing with a particular case while the goal is identical for all participants—helping the child and family.

The case conference when viewed as a social group with flexible but structured roles and democratic leadership often has the positive effect of reducing the anxiety level of those directly working with the clients or patients. While Miss Oppenheimer indicates the usefulness for staff members in learning how their colleagues view the child or family, she stresses the cognitive aspects, ". . . the total staff knowledge is enlarged. . . ." It has been my experience at case conferences when various professional fields are represented that both cognitive understanding and emotional feelings about particular problems need to be expressed. This has been particularly true of harried schoolteachers who find themselves spending less time teaching and more time in handling "problem children."

Effective interpersonal relationships among professional persons help them to be more successful when dealing with their work. If the case conference focuses *entirely* on the needs of the client or patient, an ingredient for the best possible program for the child or family involved may be lost.

Seymour Gross
Clinical Psychologist, Hennepin County Mental Health Center, Inc., Minneapolis, Minn.

RASHBAUM, et al.: *More on unmarried mothers*

Dr. Rashbaum, Miss Rehr, Miss Paneth, and Mr. Greenberg suggest in their article some ways of tackling the problems of the unmarried mother which have indeed "been of concern to social and health agencies for a long time." ["Use of Social Services by Unmarried Mothers," by William Rashbaum, Helen Rehr, Janice Paneth, and Martin Greenberg, CHILDREN, January–February 1963.]

The study itself suggests the first step—that is, that each hospital and community must analyze its own problems. Each community has its own ethnic groups with their separate and collective cultural mores and social values. Communities, like people, "wear different size shoes."

The authors' statement about the expectations of social agencies overwhelms me: ". . . they are expected to protect the well-being of the mother and her child and thus minimize the chances of further social breakdown to which unmarried mothers and their offspring are particularly vulnerable . . . to help the unmarried mother and putative father act in a more responsible way and to help curtail, if not eliminate entirely, the repetition of out-of-wedlock pregnancies."

The statement implies the public's expectations of the agencies as well as the agencies' expectations of themselves. Could it be that herein lies one of the deterrents for society's assuming more responsibility for assisting with these problems? The ways and means of meeting these expectations touch almost every aspect, both preventive and rehabilitative, of community life. To mention a few preventive aspects: better wage earning opportunities for all ethnic groups, better housing facilities for all ethnic groups, more stable family life, and better family life education, including sex education for both boys and girls, beginning in the home and continuing through school years as needed.

Through coauthorship, the study also suggests the collaborative effort of many health and social professions, both in the prevention and rehabilitation. In view of the recognized need for more adequate services for the unmarried parents and child, various professional persons, including the family physician, the obstetrician, the pediatrician, the hospital and public health nurse, and social worker, might examine how effectively they work together to provide these services. What has each professional group done to assist with the problem? Do they share a mutual concern and similar goals? Is there mutual trust in each other's contribution? Unmarried parenthood in our society is found at all economic levels. If the whole is to be examined, all economic levels must be included. Are the needs of the "private and semiprivate" patients different from the needs of the patients in the study?

The article pointed out many unmet needs that are common to most hospital communities. Indeed, many do not have some services available in the Mount Sinai Hospital area. There is across the country a paucity of adequate social service departments in hospitals. Adoption agencies, foster home facilities, and counseling services are frequently not available to regional minority ethnic groups. How can these mothers use what is not there? The study should serve as both a stimulus to do something *now* and as a guide to where and how to begin.

Euzelia C. Smart
Director of Social Service,
North Carolina Memorial Hospital, University of North Carolina

BECK: *Comment on a comment*

Bertram Beck's reply to David Kaplan in the November–December 1962 issue of CHILDREN ["Readers' Exchange," pp. 247–248] might be modified by recognizing what is being called "primary prevention," a concept which is not oriented to specific diseases nor to the early detection and treatment for such specific diseases. Rather, it seeks to alter the context in which people grow up and live—the family, the school, the neighborhood, the place of employment—and in which they develop their disorders.

A statement of this approach is given in "The Prevention of Mental Disorders in Children," (Basic Books, 1961), edited by Gerald Caplan of the Harvard School of Public Health. I reviewed this in the *American Journal of Orthopsychiatry*, April 1962, emphasizing the neglected task of primary prevention as Caplan has defined that term, and as it is being used in various organizations today. In this connection, the review of the report of the Joint Commission on Mental Illness and Health in that same issue of the journal is also relevant. Some of us are hoping that through the American Orthopsychiatric Association we may present a proposal for primary prevention to supplement the joint report that so largely neglects that task.

Beck's reply to Kaplan is relevant insofar as it indicates that approaching a social problem as an entity and seeking the supposed "cause" of that problem are not applicable to human affairs or social orders, and that the concept of prevention has been often limited to that approach. But the concept is now being reformulated in more dynamic and comprehensive terms.

Frequently social workers, like many physicians, are so engrossed by diagnosis and treatment of individuals that they fail to see that their clients or patients are the products of many different but concurrent processes which can be altered, and will be altered, when we decide that we should not waste human lives as we now do. Thus, instead of thinking in terms of large-scale superhuman trends against which man is impotent, they might think of these so-called trends as the aggregate of choices and decisions made by industrialists, educators, technologists, politicians, and others with little or no awareness of their human social consequences.

I am *not* suggesting that social workers turn aside from or neglect their present responsibilities for individuals and families, but I do believe they could and should recognize the importance of primary prevention, the tasks of which they can help to define in terms of their own cumulative experience of how human lives and personalities are being unnecessarily wasted by irresponsibility on the part of our socially sanctioned institutions.

Perhaps one of the major obstacles to the development of this approach is the single-minded devotion of each of the helping professions to its own specific and limited operations, and its disregard of and, sometimes, hostility to the work of other helping professions. All of these professions are necessary to a comprehensive program of what we call primary prevention but what might be more appropriately called the task of human conservation.

Lawrence K. Frank
Belmont, Mass.

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SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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PLANNING NURSERIES FOR NEWBORN IN THE GENERAL HOSPITAL. O. Bernard Ives. Department of Health, Education, and Welfare, Public Health Service, Division of Hospital and Medical Facilities; and Social Security Administration, Children's Bureau. PHS Publication No. 930-D-5. 1962. 26 pp. 25 cents.

Offering plans developed for hospitals of 50 to 200 beds and basic principles that apply to all hospitals, this publication includes designs for nurseries for newborn infants, both full term and premature.

TRAINING FOR JUVENILE PROBATION OFFICERS; a workshop report. Merritt Gilman and Alice M. Low. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 398. 1962. 78 pp. 30 cents.

A report of a 5-day workshop sponsored by the Children's Bureau in cooperation with the National Council on Crime and Delinquency and Wayne State University School of Social Work. With stress on the definition of the problems of inservice and professional training and their possible solutions, the contents analyze the role of the probation officer, what he needs for effective performance, and the implications of this for training.

THE FEDERAL DELINQUENCY PROGRAM OBJECTIVES AND OPERATION UNDER THE PRESIDENT'S COMMITTEE ON JUVENILE DELINQUENCY AND YOUTH CRIME, AND THE JUVENILE DELINQUENCY AND YOUTH OFFENSES CONTROL ACT OF 1961 (PUBLIC LAW 87-274); and CONDITIONS GOVERNING JUVENILE DELINQUENCY AND YOUTH OFFENSES DEMONSTRATION PROJECT AND TRAINING PROGRAM GRANTS. Departments of Justice; Health, Education, and Welfare; and Labor; 1962. 9 pp. Free on request from the Office of Juvenile Delinquency and Youth Development. Welfare Administration, Department of Health, Education, and Welfare.

Included are reports on: objectives of the Federal program; administrative organization; delinquency and related youth problems; planning and demonstration projects; personnel training projects; technical services; requirements for eligibility for grants.

A SOCIAL WORKER TAKES A CASE INTO COURT. William H. Sheridan and Pat O. Mancini. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Series "Work With Children Coming Before Courts," No. 2, 1962. 16 pp. 15 cents.

Second in a series of nontechnical guidelines for orienting new staff, this pamphlet describes the role of social workers participating in court action on behalf of children, stressing the factors which should be considered prior to court action and the responsibilities of the social worker before, during, and after the hearing.

IMPROVING HOME AND FAMILY LIVING AMONG LOW-INCOME FAMILIES. Gladys O. White, Alberta D. Hill, and Edna P. Amidon. Department of Health, Education, and Welfare, Social Security Administration, Bureau of Family Services; and Office of Education. May 1962. 24 pp. Copies available from the Bureau of Family Services without charge.

Directed to State education and welfare agencies, this publication stresses the need for joint effort to strengthen and expand programs for providing more adequate instruction in homemaking skills to low-income families.

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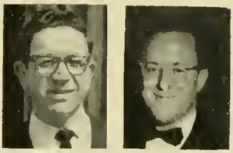
◀

MIGRANT CHILDREN with their teacher in a day-care center in Pennsylvania. Caring for the children of agricultural migrants while their parents work has become an increasing concern of welfare departments in areas which depend on itinerant farm hands in the harvesting season. How a child welfare worker fitted into a coordinated program for migrants in 3 counties in North Carolina is described on pages 87–92.

Eleanor Crocker is at present with the Associated Day Care Services of Boston, giving casework to parents of children in day care and consultation to teaching staffs. In the summer of 1961, a year before she graduated from the Boston University School of Social Work, she studied the techniques of family group therapy and the principles of community mental health administration at the National Institute of Mental Health as a summer intern.

After earning a doctorate in clinical psychology from the University of California in 1958, Martin Heinstein worked on a collaborative study of child behavior and cerebral palsy at the National Institutes of Health. Previously, he was research director at the child development center of the Children's Hospital of East Bay in Oakland, Calif. He is on the faculty of the San Francisco State College, where he teaches child development.

On leave from his present post, which he has had since 1955, Jack Parsons spent the years 1958–60 with Ceylon's Department of Probation and Child Care Services, under the sponsorship of the Asia Foundation. He has in the past been superintendent of two children's institutions and has been on the social work faculty of the University of Pittsburgh. His Ph. D. is from the University of Chicago.



Sidney Gershenson (left) is at present working with the United Community Centers of San Francisco where he will become program director next January. Meyer Schreiber (right) directed a center for retired workers in Detroit before taking his present job 3 years ago. He is field instructor for the schools of social work of Hunter College and Fordham and New York Universities.

In addition to directing the clinic for retarded children, Dr. J. William Oberman conducts a program of diagnosis and treatment for preschool-age mentally retarded children in the child health clinics of the District of Columbia. He is also assistant clinical professor of pediatrics at the Georgetown University School of Medicine.

Dr. Nathan Ackerman directs the family mental health clinic at the Jewish Family Service, New York, as well as the Family Institute which he helped to found. A pioneer in family therapy, he described some of his theories in the July–August 1961 issue of CHILDREN. He is author of the book, "The Dynamics of Family Life."

◀ *the authors*

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How three North Carolina counties include the services of . . .

A CHILD WELFARE WORKER IN A PROGRAM FOR MIGRANTS

ELEANOR CARTWRIGHT CROCKER
Former Child Welfare Worker
Camden County (N.C.) Department of Public Welfare

EVERY SUMMER some 5,500 migrant farmworkers and their families come up from Florida, Georgia, and South Carolina to Camden, Currituck, and Pasquotank Counties in North Carolina to harvest potatoes, beans, and cucumbers. At season's peak some 3,800 migrant workers and their families are in these counties at the same time. Last summer they lived in 44 camps, 20 of which had received permits from the health department. These camps housed approximately 600 children under 16.

While for several years a variety of efforts had been made to meet many of the health, welfare, and educational needs of these families, and especially their children, these were not completely coordinated until 1962 when the Tri-County area was designated as a pilot demonstration project by the U.S. Department of Labor to see what could be done with a concentration of public and voluntary services to these migrants. How the services of a child welfare worker on the staff of the Camden County Department of Public Welfare fitted into the efforts of the Tri-County Citizen's Committee on Migratory Labor, formed to carry out this project, will be described in this article.

Since 1955, Camden County has been the location of a day-care center for migrant children operated in public school facilities by the Migrant Ministry of the Elizabeth City Ministerial Association and supported by the North Carolina Council of Churches. Over the same period of time, the Camden County Department of Public Welfare has each summer employed a child welfare worker to work with the migrants, her salary being paid by the State from Federal child welfare services funds. During the 1962 season, the child welfare worker divided her time between direct services to the children and parents of the camps as well as to the staff of the day-care center, and work with the local citizen's committee to bring about more positive attitudes toward the migrants.

Thirty-five children attended the day-care center regularly during the 6 weeks of its operation in 1962. Enrolled as a result of visits to the camp by the center's director, they were picked up five mornings a week by the center's 5 staff members in station wagons belonging to the local migrant ministry. At the center they were fed nourishing food, took naps, and played together, and the older ones learned simple craft skills.

The child welfare worker used the center as her headquarters, working out of there into the camps. She did this for two reasons: (1) because the day-care center was a kind of filter center for all the program's activities; and (2) because of the de-

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Based on a report from Camden County, N.C., to the North Carolina State Board of Public Welfare.

cision to concentrate her attention on the families who had children in the center.

She was involved in the work of the day-care center in two ways: (1) direct work with the parents and staff to bring health and welfare services to the children; and (2) conferences with the center's staff to sharpen the teachers' awareness of the children's individual needs. In addition to casework with specific families in relation to special needs, her direct health and welfare activities included arranging with the local public health doctor and nurse for physical examination of the children, securing health records on the children from the parents, and helping the parents to follow up on the doctor's recommendations. She began by writing a letter to the parents who had children enrolled in the day-care center explaining the importance of health examinations and records. Then, accompanied by the center's director, or the liaison officer between the center and the committee, who already knew the parents, she visited each mother and read and explained the letter.

These first camp visits were the beginning of relationships not only with the parents who had children in the center but also with other parents and children encountered in the camps who needed medical or social work attention. They were followed in a few days by return visits during which the child welfare worker picked up the health records which had in the meantime been made out by the mothers, and distributed a 1-page directory of clinic schedules and information about her own services. The mothers turned in immunization records on more than half the day-care center's children, although only one mother had brought such a record with her to the camp. All the child welfare worker's visits to the camps were made with permission and sometimes the help of the crew leaders.

Participants at the farewell party for children given at the end of the 1962 season at the day-care center for the children of agricultural migrants in Camden County, N.C.

Although only 35 children came regularly to the day-care center, 44 received health examinations there since several mothers sent their children to the center just for this purpose. TB patch tests made on all these children were uniformly negative. Other physical defects were discovered, however, in 15 children, and the child welfare worker discussed with the mothers the possibilities of, and resources for, getting the defects corrected.

In weekly case conferences with the center's teachers the child welfare worker led discussions of the needs of specific children, each child having a turn as the focus of attention. These conferences were also used to discuss standards and suggestions for day-care centers issued by the North Carolina State Board of Public Welfare. The child welfare worker also participated in general staff meetings held at the center, conducted by the executive secretary of the citizen's committee and attended by the committee's liaison with the center, the Migrant Ministry's chaplain, the center's director and staff, and the county director of public welfare. At these meetings, ideas, feelings, and experiences were exchanged and additional plans made.

One of the season's most successful projects developed from such a general staff discussion. This was a Harvest Talent Show, conceived at first as a closing program for the children of the day-care center and their families. Since open house held for the parents had not proved successful in the past, it was thought that a program in which the children participated would be more likely to attract the parents. The original plans expanded to include talent from the various camps and local groups as well. Chief goals of the event were: (1) to help parents take pride in their children and their achievements, and to have fun with their children: and (2) to provide an opportunity for pleasant and purposeful interaction between the migrant community and local citizens.

The staff made floaters and posters which they distributed to the camps. In addition, the child welfare worker visited each crew leader to ask about talented persons in his group who might be interested in participating and also to ask for help in arranging transportation—a problem in any program for migrants.

The event was an obvious success, although the people arrived at all hours—between 8 p.m., the hour set for the program to begin, and 11 p.m., when the last potato grader shut down that night and there was no more work to do—work necessarily comes first with migrant crews. In addition to the children's part of the program, the event consisted of four acts put on by local people and five by migrants. Prizes were awarded to the winning acts and refreshments served. The 75 people who attended seemed to enjoy themselves immensely, particularly the children.

Services to Individuals

The child welfare worker provided special individualized services to 26 families during the season. Of these "special welfare service cases," 2 involved referring mothers to well-baby clinics; 3, referring expectant mothers to prenatal clinics; 1, helping a family to make appropriate arrangements following the death of an infant; 2, referring sick children to private physicians; 4, providing casework services to emotionally upset adults; and 10 involved certifying families for U.S. Department of Agriculture surplus foods. These last were families who remained in the area after the harvesting season closed because they could not find work elsewhere. During her visits to these families, the child welfare worker distributed magazines and health kits and organized games for the children.

An emergency fund of $25, created by a private donor, was used by the child welfare worker for making small individual loans. This proved especially helpful when medical attention or medicine was needed quickly. In at least two instances loans for medicine saved the borrowers from hospitalization and the county a medical bill.

The following examples illustrate some of the directions in which the child welfare worker provided casework help.

Corinna, a teenage girl, was referred by a crew leader's wife when the worker visited a camp to secure vaccination records. She had been "acting crazy" since the weekend, running up and down or withdrawing and talking with no one. She was alone on the crew, and although some of the people knew her home town, no one knew her address. By following a clue on a medicine bottle in the girl's possession, the child welfare worker learned that the girl was an epileptic. Appropriate medication, prescribed by the county health officer, was secured for her by using money from the emergency fund. Eventually the girl was able to give her mother's name and address. She then gave the child welfare worker permission to write her mother and ask for aid in returning home. Soon afterward, the mother arrived from Florida to get her daughter, saying that the girl had run away from home and that she had been "worried sick" about her.

* * *

A pregnant woman, separated from her husband, had arrived at the camp with three preschool children, one of whom had severe asthma, and two, pinworms. She said she had come with the group because her sister was the crew leader's wife and because she was not making enough money in Florida to feed her family and keep the children at a day-care center while she worked. In a series of interviews with the child welfare worker, she focused mainly on her great fear of childbirth, which derived from her knowledge that she had a heart condition and from the fact that she had spent $45 on abortatives and was now afraid that the expected child would be a "tadpole or worse."

Because this woman had read many popular articles on illness and disease, the child welfare worker gave her articles and pamphlets about pregnancy and birth, as well as material on child rearing which they discussed together. She made arrangements for the woman to visit the prenatal clinic and for her children to see the doctor at the day-care center and tried to help her both accept and prepare for the new baby by encouraging her to begin a layette from used clothing available at the center. The child welfare worker also discussed with this mother the possibility of taking steps to secure support payments from her husband upon her return to Florida.

* * *

Miss W and her diabetic son were referred to the child welfare worker by the health department. The child had just been taken to the hospital as a result of not receiving his appropriate insulin dosage. Miss W and her three illegitimate children had come along on the crew with Miss W's mother. She had never traveled before because of her son's disability and had not taken into account the change in diet and exercise while traveling. She seemed to be a very dedicated mother who made every effort possible to regulate her son's diet as the doctor prescribed.

In Florida the family had been on the ADC rolls and had received insulin from the county. Miss W was very much upset to find that she could not do the same everywhere. She had just arrived, had not worked, and therefore had no money. The child welfare worker lent her money for a week's supply of insulin from the emergency fund, asking that the money be paid back so that others in need could be helped. With this medication, the boy's dosage was readjusted and he was released from the hospital. Shortly thereafter, Miss W decided that she had better move on to New York or return to Florida as quickly as possible in order to be surer of getting insulin for her son.

Community Interaction

One of the chief goals of the Citizen's Committee on Migratory Labor was to foster positive attitudes toward the migrants on the part of the local citizenry. The child welfare worker had lived in the Tri-County area most of her life and thus was familiar with local feelings toward the migrants, the majority of whom were Negroes of economically and educationally deprived backgrounds. Since the prevailing reaction to them among the local people seemed to be fear, she worked consciously to bring about a more widespread realization that the depredations of a few persons who did not know how to take care of the facilities provided them did not mean that all migrants were characteristically wanton persons. Thus she helped the committee to create new opportunities and seized every chance opportunity offered to increase favorable interaction between the migrant community and the local people.

The Tri-County Citizen's Committee on Migratory Labor (now the Albemarle Council on Migratory Labor) was composed of local citizens and professionals who served on seven subcommittees: executive; health and welfare; finance; volunteer social service; recreation; audiovisual materials; and public relations. The child welfare worker served on four of these and became involved in some way with all of them. She also served as secretary of the executive committee, and of the health and welfare committee.

Health and Welfare Committee

In working with the health and welfare committee the child welfare worker was particularly active in three of the committee's projects:

1. *The sponsoring of awards for the crew, crew leader, and grower whose campsite was kept in the cleanest and safest condition.*

The purpose of these awards was to encourage the crews to take better care of the grower's property and thus foster better relationships between owner and workers. The public health sanitarians and agricultural extension agents in each county prepared a score sheet, and visited 31 camps in the 3 counties in order to rate them.

The child welfare worker helped make arrangements with the growers for the prizes and presentations. She and the employment security interviewer from the U.S. Department of Labor visited each crew leader in Camden County, gave them material, discussed the purpose of the awards, and told them when the inspection team would visit their camp. Crew leaders in the other two counties were notified through the Employment Security Commission. After the scores were tallied, presentation ceremonies were held in all the counties. The winning crews were given watermelons, and the crew leader, grower, and all second place winners were given certificates. The growers seemed pleased with the project and asked that it be repeated the following year.

2. *The establishment of a first-aid course.*

The Red Cross representative on the health and welfare committee stated early in the summer that volunteer instructors were willing to conduct first-aid courses in the camps if the child welfare worker would make the necessary arrangements. One of the difficulties was finding a time when both migrants and instructor could get together. The child welfare worker surveyed one of the camps and found 16 young people who said they would be interested in taking the course. With the permission of the crew leader, she and a Red Cross instructor visited the camp together one lunch time and met with this group. It was decided to hold the classes on Sunday morning. Twenty-one persons attended the first meeting. However, the instructor, who had never visited a migrant camp before, was so impressed with the interest and background of the group that he switched from a junior to a senior course, and as a result half the class dropped out. Nevertheless, seven persons completed the course and were awarded Senior Red Cross first-aid certificates. The local Red Cross Chapter lent the project books so that the students could study between sessions.

Plans are underway to increase the number of classes for migrants in 1963 and to introduce courses in maternal and child care.

3. *The operation of a clothing store.*

In line with its policy of helping the migrants help themselves, the health and welfare committee decided to open a used clothing store rather than to distribute clothes free. The store was located in the day-care center and did its most active business on Saturday night when a recreation program for teenagers and adults was also held in the center. Both the child welfare worker and center staff helped run the store but the bulk of the work was done by the members of a local Negro woman's club. The club members were on hand each Saturday night, helped with the sales, played with children while the mothers shopped, and totaled bills.

Approximately $60 was collected from clothing sales. The clothing receipts went back into the program to help buy recreation equipment, and the migrants were informed of this by the saleswomen and through posters.

The clothing store provided an excellent opportunity for the child welfare worker to meet and further relationships with individual migrants. Family plans and concerns were easily discussed as she helped a mother look for clothing. This was especially true in respect to pregnant women who were looking for layette pieces. It was easy to go from a discussion of an infant's clothing needs to a consideration of related necessities—sterilized bottles, diaper changes, immunization shots. Two referrals to prenatal clinics were made in this way.

A fourth project of the health and welfare committee did not get off the ground last year, but groundwork was laid for carrying it forward this year. After the season was already underway, plans were initiated to employ a homemaker to work with the migrants with funds available from the State Board of Public Welfare. The child welfare worker talked in several camps about the uses of a homemaker and also interviewed three applicants for the position. However, it was finally decided that because the season was so far advanced, it would be best to postpone the program for another year. The public welfare boards of the three counties have approved the position and several applicants have already taken the merit examination. Plans are to use the homemakers for both education and service.

Recreation Committee

A successful part of the migrant project was the weekend recreation program provided at the day-care center by two committees—one on audiovisuals, which arranged for Saturday night movies, and one on recreation, which sponsored Sunday afternoon athletics. The committee on audiovisuals was headed by a professor at the State Teachers College, who arranged for his students to get field-work credit for helping to run the movies. The chairman of the recreation committee, a local businessman, provided equipment free for the athletic program.

The chief difficulty faced in the weekend recreation program was the same encountered by any phase of work with migrants—setting a time at which most of the migrants would be free. Many migrants work until late Saturday afternoon and then must do their grocery shopping or washing at the laundromat. Transportation was also a problem. Nevertheless, about 25 persons usually attended the movie, many of them attracted by the clothing sale, and 60 to 75 persons usually participated in the athletic program, most of them teenagers.

In connection with these programs, the child welfare worker personally contacted crew leaders in the various camps, enlisting their help in putting up posters and distributing fliers announcing the programs. On Saturday night she helped with the clothing sales, played quiet games with the children, and visited with the people who came, using the opportunity these activities provided to find out more about their needs. On Sunday afternoons she organized games for the younger children, such as croquet, horseshoes, and dodge ball.

The recreation chairman received considerable criticism from some local citizens for his participation in the program, which seemed to add to his determination to demonstrate that the migrants could take advantage of and enjoy an athletic program. And they did. There was not a single unpleasant incident during the entire season. Plans for this summer are to try to draw more adults into participation in the program.

Public Relations

The child welfare worker worked closely with the editor of the local paper, who was chairman of the public relations committee, in efforts to get news coverage for all special events involving the migrants. She also wrote a feature article for the paper on the role of social work within the program.

The project also received considerably favorable publicity through other channels, much of it due to the interest of one reporter for an out-of-State paper read widely in the area. His series of four feature articles, with pictures, introduced many local people to the idea of the migrants as people with normal human needs and ambitions. One response to this was a check for $150 and a moving van filled with clothing, toys, and health kits sent to the day-care center by a group of women from nearby Suffolk, Va. An article in the *Raleigh News and Observer* also brought some response in cash as well as many encouraging letters.

The local radio station also participated in publicizing various aspects of the migrant program through spot announcements on the needs of and facts about the migrant population.

In all these efforts problems of the growers and the community as well as of the migrants were presented.

As to the Future

As a result of her experiences with the migrant program in 1962, the child welfare worker made a number of recommendations for the future.

To the future child welfare worker:

1. Attend pre-season meetings with growers and with crew leaders to become acquainted with them and make herself and her role known.
2. Make at least two early visits to the migrant camps, planned for in advance with the Employment Security Interviewers of the Labor Department, to become acquainted with the crew leader and his wife and other indigenous leaders.
3. Help the day-care center director in enrolling children by visiting camps and talking with mothers, gathering health information on the children in the process.
4. Prepare a directory of health and welfare resources for crew leaders and workers.

5. Help the homemaker, if one is available, plan and carry out needed services.

6. Work from the day-care center back to the camp.

7. Be aware of cultural influences as well as personality factors in dealing with individual migrants.

8. Keep a flexible time schedule!

The child welfare worker found that many attitudes, traits, and problems she encountered in working with the migrants were closely linked to the culture of the group. For example, the migrants who come to these three North Carolina counties are apt to be impulsive and to operate on a completely different time dimension than the local citizen. They are slow to trust the outsider, and communicate with difficulty, frequently echoing affirmatives and nodding in understanding, when they in fact have not grasped the impact of what has been said.

The importance of flexibility in time schedules in dealing with the migrants derives from the facts that they must work every possible minute they can, adjusting their working hours to the grower's needs, and do their shopping whenever the crew leader provides transportation to town. Thus it is sometimes necessary to visit families in the fields or go to the camps on rainy days when most of the migrants are apt to be there.

To the health and welfare committee:

1. Find a way of providing a mobile health unit to make the round of the camps soon after the migrants arrive.

2. Encourage the counties to follow through on the plans to make homemakers available to migrants in each of the three counties.

3. Increase the emergency fund by requesting $25 per county from the citizen's committee.

4. Utilize the services of the home agents of the Agricultural Extension Service, who have indicated their willingness to give home improvement and charm courses to the migrant women.

5. Encourage the subcommittee on house and grounds awards to meet with the growers in early spring to enlist their support for the program.

To the recreation committee:

1. Continue the weekend recreation program in 1963.

2. Enlist the cooperation of crew leaders to provide transportation to the center on weekends.

3. Begin the Saturday night program with a clothing sale before the movie and provide activities for the children while the parents shop.

4. Make greater efforts to involve adults in the Sunday afternoon program.

5. Request the Elizabeth City State Teachers College to continue its program of field-work assignments for their students in the program, and make efforts to secure other volunteers as well.

6. Hold the Harvest Talent Festival on Sunday afternoon and make the "house and grounds" awards during this event.

Conclusion

The organization of the citizen's committee for the Tri-County area has combined what were more or less individual efforts into a collaborative effort by agencies, growers, professionals, and citizen volunteers to help the migrants meet their basic human needs better and in doing so to help them to become more respected citizens. The importance of what this had accomplished so far is not diminished by the fact that many migrant problems remain. Their solution calls for legislation, particularly the enactment of measures to require crew leader registration and to provide social security coverage and health and accident insurance for migrant workers and funds for short-term education projects.

The author, who was the child welfare worker whose activities are described in this article, believes that one of the major accomplishments of the 1962 program was the beginning of a changing attitude on the part of local citizens toward the migrants. This was evidenced by their response to the program and by the growers' gradual acceptance of the citizen's committee and its purpose. While only a few growers were actively involved in the program, the strong negative feelings toward the migrants often expressed by growers in the past seemed to be absent. This change was undoubtedly helped by efforts of the citizen's committee to consider the grower's interests as well as to help him see the migrant as a person with capacity and abilities which can be developed if given a chance.

A study relating mothers' attitudes and length of nursing to the . . .

INFLUENCE OF BREAST FEEDING ON CHILDREN'S BEHAVIOR

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BREAST FEEDING has at times been singled out as the royal road to successful mothering and mental health for the child. Freud, through his concept of orality, made the nursing experience of the infant a central issue in the study of personality. His clinical findings and speculations about oral gratification and deprivation have received a great deal of attention in the literature about child development.

Nevertheless, the effects of various nursing regimes on a child's physical and emotional development are still essentially unknown. Equally obscure are the influences which induce a mother to feed her child from the breast. Few facts have been established despite speculation dating back to Hippocrates and a considerable amount of recent research.

A decline in the proportion of mothers in this country who breast feed has been apparent over the past several decades, although significant geographic differences have been noted in the frequency of the practice.[1-3] Research carried on in the 1930's and 1940's showed mothers from lower socioeconomic groups undertaking breast feeding more frequently and weaning their children later than mothers with higher socioeconomic status. Some recent studies indicate that these differences may now no longer exist or may even have been reversed.[4, 5]

Much of the research about the influence of breast feeding on child development has suffered from some obvious defects. None of the studies have attempted to evaluate the personality of the mother doing the the feeding as well as the type of feeding being done. Nor have the studies taken into account the possibility that a tense, breast-feeding mother may present a more disturbing environment for an infant than a relatively relaxed, bottle-feeding mother. Furthermore, few, if any, studies have looked for possible differences in reactions on the part of male and female children, or to possible variability of response with the age of the child. Behavior disturbances apparent at the time of weaning may not be present at subsequent stages of development.

Studies have usually relied too heavily on retrospective data. Reports from mothers several years later on how they fed their babies and their children's later reactions are likely to be unreliable. Moreover, investigators have usually studied only special groups, such as middle-class families or children being treated at a clinic. Few studies have used samples representative enough of the general population to permit broad deductions.

The study to be reported upon here made use of longitudinal data collected on a representative sample of children—a sub-sample of every third child

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Based on a monograph to be published by the Society for Research in Child Development. This monograph will contain the supporting data on which the findings of the study reported in this article are based.

born in Berkeley, Calif., from January 1, 1928, to June 30, 1929. The data covered a period from the birth of the child to 18 years of age. Behavior problems of the children during the preschool period, middle childhood, and adolescence were looked at in relation to whether or not the children were breast fed, the length of their nursing experience (whether from breast or bottle, or both), and the family atmosphere during the nursing period.

The term *nursing* will be used in this article, as it was in the study, to refer to the period of breast and bottle feeding, or both. *Length of nursing* was determined by fixing the time at which the child was weaned to the cup.

The 47 boys and 47 girls in the sample had been studied intensively for physical, mental, and personality development by the Institute of Human Development at the University of California, Berkeley. Data were also available on the general characteristics of the parents, the mother's relations to the child, and the socioeconomic status of the family. Testing and intensive, open-ended interviews had been conducted periodically over the 18-year period. The sample and program of data collection have been described in previous publications.[6]

Study Variables

The main variables considered in this study were: (1) breast feeding without supplementary nursing; (2) length of nursing; (3) the warmth of the mother toward the child; (4) the nervous stability of the mother; (5) the marital adjustment of the parents; (6) and the behavior problems of the child. The warmth of the mother was determined by a combined average rating of the mother's closeness to the child, general friendliness, and expressiveness of affection toward her child.

The behavior of the child was evaluated both from reports of the mother, starting when the child was 21 months old, and interviews with the child starting when he was 6 years old. Ratings on behavior problems such as temper tantrums, thumb-sucking, fears, and enuresis were used for the preschool period and middle childhood. The results of projective testing by the Thematic Apperception and Rorschach tests were the basis for behavior assessment in late childhood and adolescence. Ratings of the personalities of the parents, their relations to each other and to their children were based on the reports of the intensive interviews.

While no other studies to date have looked into the joint influence of the mother's personality and the nursing process on the child's behavior, a number have focused on the characteristics of mothers who did and of those who did not breast feed. Some of these studies have been based in part on the supposition that the mother's personality and her feelings toward the child are related to her decision to breast feed or not. For example, Levy at one time maintained that weaning was an index of maternal rejection.[7]

On the other hand, two studies [8, 9] reported 16 years apart found no evidence that breast feeding was related to whether the mother wanted the child or to the degree of warmth of the mother toward the child. One of them, however, indicated "that breast feeding probably does have some special implications for quite a good many mothers, and that those who have a strong sense of modesty or anxiety about sex, in general, may avoid breast feeding."[9] Another study found that the "biologic type" of mother prefers to breast feed and to avoid a rigid schedule, while the "modern urban type" tends to bottle feed on a rigid schedule.[10]

In the present study, none of the variables used to define the mother-child relations or the general family atmosphere was found to be significantly related to breast feeding. For example, factors such as the warmth of the mother toward the child or the marital adjustment of the parents were not associated with breast feeding or with the duration of breast feeding. Thus the data can hardly be interpreted as representing evidence that breast feeding is a reliable measure of maternal acceptance of the child.

The socioeconomic status of the family, however, was associated with the duration of breast feeding. For both boys and girls, the lower the socioeconomic status of the family, the older the age of the child at weaning from the breast.

The relationship of lower socioeconomic status with longer duration of breast feeding is consistent with the results of other studies using breast-feeding data from about the same period (1928–29). As already mentioned, more recent investigations tend to indicate no differences in this respect between social classes while some studies report longer or more breast feeding by middle-class mothers. Possibly the recent rise in the proportion of mothers from lower socioeconomic groups who are working outside the home has decreased the opportunity for breast feeding among them. At the same time, the emphasis in pediatric and child development publications on the psychological benefits of breast feeding for the child has probably been influential in fostering positive attitudes toward breast feeding among middle-class mothers. The relatively greater decline of breast feeding among mothers of the lower socioeconomic levels may also mean, at least in part, that these mothers have reached standards of child care followed by middle-class mothers several decades ago.

Health and Behavior Problems

The study gave no evidence of breast feeding being positively related to favorable growth or general health of the child. On the contrary, length of breast feeding for both boys and girls correlated negatively with the rate at which the children reached various heights—one index of maturation. Four of six overall health ratings also correlated negatively with breast feeding. The health ratings were based on periodic physical examinations and frequency of illness. The study was not designed, however, to answer specific questions about the relation of breast feeding to health.

The study also failed to reveal significant differences in incidence of problem behavior between breast-fed or bottle-fed children—whether boys or girls. The findings of previous studies are noticeably inconsistent in this respect. In four studies, children who had been breast fed for 4 to 10 months were better adjusted than children who had been breast fed shorter or longer periods. Three studies reported that the later the weaning from the breast the fewer the behavior problems. Two other studies, in direct contrast to the first four mentioned, indicated that the best adjustment was among subjects breast fed for very short periods or not at all, or for a long period (11 or 12 months). Four other investigations found no significant differences in behavior according to the length of breast feeding.[11]

Parental Factors and Nursing

Psychologists who are influenced by learning theory and psychiatrists who place more emphasis on interpersonal transactions than on libidinal drives have regarded the personal-social environment of the child as fundamentally more important than a particular nursing regime. They have maintained that positive, early relationships of the child with the parents, particularly the mother, are likely to carry over to other later interpersonal relations.

The results of this study revealed that in general the daughters of the more stable or of the warm mothers had fewer behavior problems. For boys, only the warmth of the mother was associated in any degree with positive behavior. The marital adjustment of the parents showed no noticeable association with the behavior of either boys or girls when this factor alone was considered in relation to behavior problems.

Findings based on such single factors in the child's environment as the warmth of the mother, her nervous stability, or the marital adjustment of the parents were not as pronounced as the associations apparent when both the parental characteristics and the nursing situation were considered at the same time. In fact, the results of this study seem to indicate that the interaction of the nursing and parental factors are more important for the adjustment of the child than either the nursing situation or parental characteristics taken separately.

While the nursing situation by itself did not seem to relate significantly to later behavior, it became a variable of importance when considered in connection with parental attributes, the sex of the child, and differences between the experience of breast feeding and length of nursing as such.

The most pronounced maladjustment shown in any group in the study was among boys who were nursed (on breast or bottle) for a long period of time (15 months or longer) by a *cold* mother (distant, hostile, inexpressive of affection). Length of nursing when considered apart from the personal characteristics of the mother doing the nursing, was not associated with any noticeable behavioral disturbances. Furthermore, boys who were nursed for a long period of time by a *warm* mother tended to be relatively free from behavioral difficulties. What became evident was the effects of experiencing *both* long nursing and a cold mother at the same time.

Extended nursing in our culture may be regarded as a sign of continuing dependency needs on the part of the child. The mother who accepts or fosters these dependency needs, but at the same time has feelings of rejection toward the child, is obviously ambivalent and providing an atmosphere of conflict for the child. Such a mother is perhaps not truly nurturant, but may use the dependence of the child as a basis for maintaining hostile control.

Dependence in the first years of life is not likely to be maladaptive if it is expressed and met within the context of genuine feelings of nurturance on the part of the mother. The boys in this sample who were long-nursed by a cold mother were, in effect, experiencing oversolicitousness and hostility at the same time. Too much from a mother who in reality is able to give only too little is likely to result in confusion for the child.

Long nursing (weaned from the breast or bottle at 16 months or later) as such showed no significant overall association with behavior problems for girls, as it did for boys. However, when the results of the interaction between length of nursing and the maternal nervous stability were considered, girls who had a relatively unstable mother had fewer behavior problems when they were nursed for a long period of time. A shorter total nursing period was the most favorable duration when the mother was more stable.

Possibly mothers unable to provide a generally stable atmosphere for their daughters are able to compensate by added solicitousness in the nursing area. The capacity of the girl to benefit from a longer period of nurturance through nursing may reflect cultural differences in our demands for independence from boys and girls. Girls may be able to receive reinforcement of dependency needs longer than boys without being subjected to conflicting expectations that they become more independent and aggressive. This, of course, is clearly speculative. Apparently, however, boys and girls experience length of nursing in different ways depending, in part, on variations in personal-social environment.

Breast Feeding and the Mother

What about the effects of breast feeding generally when considered along with the feelings of the mother doing the feeding? For boys, breast feeding did not appear to be significantly related to problem behavior even when considered in the context of mother-child relations at the time of nursing. Whether the mother was warm or cold in her feelings toward her son was not associated with noticeably different kinds of behavior. In other words, the interaction of breast feeding and the warmth of the mother was not significant except when length of nursing was taken into account.

Girls, however, developed fewer behavioral difficulties if breast fed by a warm mother. However, those whose mothers were distant, unfriendly, and inexpressive of affection did better if bottle fed.

It is not unreasonable to suppose that the mother who breast feeds her daughter without real warmth provides an ambivalent and potentially more disturbing environment for her—a situation similar to the one experienced by boys fed by a long nursing, cold mother. The close, intense relationship between mother and daughter implied in breast feeding apparently should be part of a more generally warm mother-child relationship in order to effect lasting psychological benefits for the child. Where technical nurturance represents only a formal expression of love or when it occurs with feelings of rejection, the resulting confusion for the child again appears to be associated with behavior problems.

Why boys were unfavorably affected by the *long-nursing* situation with a cold mother and girls by *breast feeding* with a cold mother is not readily apparent. The ambivalence present in both of these general conditions, however, is clear.

The fact that behavioral difficulties seem to be generated by the long nursing-cold mother experience of the boys in this study and the breast feeding-cold mother situation of the girls has some relevance for the "double bind" theory of Bateson and associates.[12] It also has implications for Harlow's[13] findings on the importance of cuddling.

The main ingredients of the double bind, as described by Bateson, consist of two or more people in a repeated experience from which one, the victim, has no escape. The victim receives a primary negative (or positive) injunction which is in conflict with a more abstract secondary injunction. Thus the boys in this study who experienced a long nursing period with a cold mother were caught in a relationship in which the mother was expressing two orders of message, one of which denied the other. Technically, the long nursing or the breast feeding expressed a formal manifestation of nurturance or love, which was contradicted by a communication of the mother's feelings of hostility and lack of closeness.

Harlow's early work suggests the possibility that the amount and kind of cuddling the infant receives are more important psychologically than the nursing experience. While some of the evidence from the study described here indicated that the warmth and nervous stability of the mother as single factors in the child's early experience were more important than the nursing situation, the pattern of both factors together, nursing and the mother's personality, seemed to be the most decisive influence.

Implications of the Study

The results of this study point to the dangers of making oversimplified recommendations in relation to specific child-rearing procedures without consideration of the family atmosphere in which these procedures are to take place. Breast feeding or long nursing are not efficacious *per se*. In each instance, we must ask who the nursing mother is and what the other relevant factors in the home environment are which impinge on the nursing experience of the child.

Further evidence supporting these observations may be gained from the study's findings in relation to thumb-sucking. Freud used thumb-sucking as a model for explaining the erogenous nature of the oral zone. As a result thumb-sucking has become a diagnostic sign for insufficient sucking satisfaction, disturbed emotional development, troubled mother-child relations, and a host of other ills. Levy, for example, has stated that the main cause of finger sucking is insufficient sucking at the breast or bottle.[14]

The greatest incidence of thumb-sucking in this study occurred among girls who were breast fed by mothers who had achieved a good marital adjustment and who were also judged better than average in regard to nervous stability. Not only are the results the reverse of what would be theoretically expected, but, again, the interaction of two factors, the breast feeding and the parental characteristics, was more significant than the effects of either variable considered separately.

Moreover, the results in this study and in two additional investigations based on large, representative samples of children, thumb-sucking was negatively correlated with other behavior problems in the preschool period. The thumb-sucking girl tended to come from a breast-feeding, stable environment, and girls and boys who as preschoolers sucked their thumbs were less likely than others to have other behavior problems.

Perhaps the most important conclusions of this study relate to the several methodological considerations raised in the early part of this article. Apparently sex differences *are* an important factor in evaluating the behavioral correlates of the nursing experience. Also, the pattern of the child's nursing experience within the context of varying personal-social conditions seems to provide a more decisive view of the child's emotional adjustment than do single factors, be they the nursing experience or particular characteristics of the parents.

The zeal of some people in trying to foster breast feeding or a particular child-rearing technique may derive from an oversimplified interpretation of psychoanalytic theory or a long held idyllic picture of mother-infant oneness. It is perhaps wiser without more definitive knowledge to view nursing as one aspect of the total life space of the infant or child. While the results of this study must also be viewed with caution, they do seem clear enough to raise serious doubts about some of the current *ex cathedra* pronouncements which appear on the topic of breast feeding or baby nursing in general.

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[1] Bronfenbrenner, U.: Socialization and social class through time and space. *In* Readings in social psychology. (E. E. Maccoby et al., eds.) Holt, Rinehart, and Winston, New York. 1958.

[2] Meyer, H. F.: Breast feeding in the United States: extent and possible trend. *Pediatrics,* July 1958.

[3] Robertson, W. O.: Breast feeding practices: some implications of regional variation. *American Journal of Public Health,* July 1961.

[4] White, Martha S.: Social class, child rearing practices, and child behavior. *American Sociological Review,* December 1957.

[5] Bock, W. E.; Lawson E. D.; Yankauer, A.; Sussman, M. B.: Social class, maternal health, and child care. New York State Department of Health, Albany. 1957.

[6] Macfarlane, Jean W.: Studies in child guidance. I. Methodology of data collection and organization. *Monographs of the Society for Research in Child Development,* 1938.

[7] Levy, D. M.: Maternal overprotection. Columbia University Press, New York. 1943.

[8] Peterson, G. H.; Spano F.: Breast feeding, maternal rejection, and child personality. *Character and Personality,* September 1941.

[9] Sears, R. R.: Maccoby, E. E.; Levin H.: Patterns of child rearing. Row, Peterson and Co., New York. 1957.

[10] Newton, N. R.; Newton, M.: Relationship of ability to breast feed and maternal attitudes toward breast feeding. *Journal of Pediatrics,* May 1950.

[11] Heinstein, M.: Behavioral correlates of breast-bottle regimes under varying parent-infant relationships. *Monographs of the Society for Research in Child Development.* In press.

[12] Bateson, G.; Jackson, D. D.; Haley, J.; Weakland, J.: Toward a theory of schizophrenia. *Behavioral Science,* October 1956.

[13] Harlow, H. F.: The nature of love. *American Psychologist,* December 1958.

[14] Levy, D. M.: Finger sucking from the psychiatric angle. *Child Development,* March 1937.

In distinction to the original sin that is believed to be part of man's inheritance, some original goodness must also be recognized. With all the evil and cruelty and injustice that exist in the world, there are still "reservoirs of compassion" in mankind that have scarcely been touched.

From an editorial in The New England Journal of Medicine, *November 1, 1962.*

An experience in Ceylon provides some principles for consultation on . . .

CHILD WELFARE IN A DEVELOPING COUNTRY

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DETERMINING THE PACE at which to proceed is one of the most important decisions that a technical consultant to a developing country has to make. While rising expectations are everywhere apparent, the advances made with respect to children's welfare are too often of a pedestrian nature. This is true in spite of the expressed desires in some developing countries to "catch up" with other nations in child welfare achievements through embarking on crash programs. Counteracting these expressions, however, are others against any change, or warnings against moving ahead at any perceptible rate of speed.

A closely related problem facing the consultant in a foreign culture is determining his role: Does he follow in the "wake of social change," concentrating on helping people adjust to new situations? Or is he the transmitter of fresh values, the symbol about which the expectation of change revolves?[1] While definitive, final answers to these questions may not be possible, their solutions may in part lie in a variety of factors, including the stage of development of the country, the resources available, and the experience of those who are there on foreign assignments.

As a technical assistant in child welfare for 2 years in Ceylon, the author of this article faced both these problems.

In its organization of social welfare services, Ceylon presents a rather complex picture of public and voluntary services. The Department of Probation and Child Care Services, the major child-caring agency, was established in 1956, about 8 years after Ceylon achieved its independence from Great Britain. The original cadre of probation officers was at that time transferred from the Department of Prisons and has since been assuming child welfare duties in gradual stages. The Department of Probation and Child Care Services offers service throughout the island through 115 field service officers who are grouped under 7 districts, each district being administered by a chief probation and child care officer. The field service officers make social reports to courts in regard to children and adults brought before these courts, supervise persons released on probation or on court supervision orders, act on adoption inquiries, supervise children released from certified schools (public training schools for delinquents) and approved schools (private training schools), and provide protective services to deprived or abandoned children.

The Department also has responsibility for licensing and inspecting voluntary institutions as well as for administering grants-in-aid to about 115 voluntary institutions that are caring for dependent, neglected, and abandoned children. It also administers six certified schools, all for boys, three detention homes and three receiving homes. Other certified schools, including one for girls, are in the process of being established.

The Department of Social Services, another public agency, administers public assistance and a beginning social insurance program, as well as grants to agencies operating crèches, to schools for deaf and blind children, and to a few children's institutions.

Voluntary institutions represent the major resources for the care of children away from their own homes in Ceylon today. They are much older than the public services for children, the oldest having been established over a century ago, and grew out of residential school programs established by various missionary groups.

Sponsorship of the institutions has been primarily by religious bodies, with the Roman Catholic Church having nearly two-thirds of the total children under care, the Protestant denominations having about 15 percent, and the Buddhist and Hindu religions each having about 10 percent of the children. In a culture which is predominantly Buddhist, the above distribution and sponsorship is not looked upon with favor. The Buddhist lay groups are attempting to change these proportions with all possible speed.

While most institutions for dependent and neglected children are combined with educational programs, some offer only residential care. A few institutions are specialized: for children with physical handicaps; for the mentally retarded; for young convalescents; or for blind and deaf children.

In 1960 public grants-in-aid were paid with respect to some 5,000 children under care in voluntary institutions. Approximately 7,000 children in all were estimated to be in institutions, or .2 percent of the child population under 19 years of age. Two-thirds of them were girls, possibly a reflection of the greater protection given females in the Ceylonese culture. Half of all children in the institutions were between the ages of 9 and 16 years. Approximately 8 percent were under 5 years of age and almost 3 percent were under 1. While the average age at admission was 7½, about 12 percent of the total had been admitted before they were a year old.

A Broadened Function

The 2-year project in which this consultant was engaged was originally perceived as a research task directed toward helping the Department of Probation and Child Care Services to learn more about the boys sent to its certified schools, so that better commitment policies could be effected and better treatment programs offered, and to devise some measures for gauging the effectiveness of the institutional program. Plans also called for the establishment of a permanent research office to serve the Department.

Upon arrival, the consultant was asked to assist in the training of the Department's staff as well as with the research. Such a switch in assignment is not unusual in the experience of foreign consultants for definitions of the job for which they were recruited often do not fit the needs of the country, usually because changes have taken place before or shortly after the consultant's arrival. This writer's decision to accept the request to serve as both research and training consultant was based upon several considerations: (1) the institutions were still in the construction stage, with the major work being done by the boys themselves, and any study of the program then prevailing in them would not have been typical of the programs that would be established once the housing, schools, and shops were completed; (2) the inclusion of training with research allowed for closer coordination between the institutional staff and the Department's field staff so that continuous responsibility for planning for each institutionalized boy could be achieved.

Use of Resources

The Department's two assistant commissioners, one in charge of field staff, the other in charge of institutional workers, took the major responsibility for organizing and conducting all research and training efforts, with the consultant playing a variety of roles. While the training aspects of the project occupied the greatest amount of the consultant's time, he also provided consultation on small studies on aspects of the institutional program.

The consultant very early became aware of a general lack of knowledge in the Department about existing resources. There had never been gathered together in a form the workers could use any file or list of the multitudinous social, health, recreational, and educational agencies in the country. Here the project's combination of research and training had some immediate values, for it set the stage for preparing the first nationwide directory, with over 3,000 entries. This was accomplished with the help of every field officer and chief probation officer and through the assignment of a senior officer to the research office to edit and arrange the material.

From the inception of the Department, the need for an orientation and training program for newly recruited officers had been recognized. In addition to a course for beginning workers, the Department had been holding an annual refresher course of 3 or 4 days for all field staff and institutional workers. Upon these beginnings the new training program was built.

One of the major problems that had to be faced was where to get the personnel to assist in the training programs. While the consultant could and did serve in a teaching, advising, and planning capacity, there was a question of how any contribution made in this way could be of lasting value.

In the discussions which sought to plan for a more complete and ongoing staff development program, the existing resources and potential resources were reviewed. One suggestion was to make better use of existing staff with special training or experience. The Department's two psychiatrists, the chief probation and child care officers who had each received 6 months of training in the United Kingdom, and the senior officers who had demonstrated a high quality of work were drawn into the training program.

Although the psychiatrists had been employed to provide treatment, their talents had been used occasionally for teaching staff and they readily acquiesced in a plan that would take more of their time for staff training with special focus on human growth and behavior. Later on, under their own plan, they began to serve the district offices as consultants.

The use of the chief probation and child care officers in a training capacity not only furthered the work of the Department directly but also helped these officials recognize more fully that they had a responsibility for teaching as well as administration. While some did better at teaching than others, in the main their training contribution was good. Furthermore, these experiences helped them to use part of their quarterly field staff meetings for case discussions, rather than as heretofore for purely administrative matters.

Training Programs

In the training plan, the senior officers were regarded as the potential supervisory staff for new trainees after they themselves had completed a more formal course of training. Plans were developed to send them away for additional training, but meanwhile short courses in supervisory methods were presented in an effort to provide a structured field training period. While this arrangement was something of a makeshift, alternatives were lacking.

To develop case material for teaching purposes, the familiar device of requesting submission of "successful" case examples was used. Cases were particularly requested from senior officers whose work was considered outstanding by their superiors. Other cases were found through sampling procedures and through the consultant's visits to local offices. When cases were found which illustrated the principles of social work that were to be presented in the teaching, they were carefully edited and pertinent excerpts extracted. These local cases proved to be far more acceptable to the workers than cases based on experiences in other cultures. The techniques of selecting and editing cases for training were also taught.

The question of whether social workers in another culture can or should accept American social work principles is frequently raised. The consultant found for the most part a ready acceptance of these principles in the Buddhist society of Ceylon. For example, acceptance of the principle of confidentiality was illustrated by a simple incident reported during an area staff conference. One worker described the villagers' habit of following him to a client's home with the expectation of listening to the interview. The worker was asked what he did when confronted with this situation. He replied that he politely but firmly asked the bystanders to leave, to which they acquiesced.

The principle of self-determination was especially acceptable. This is understandable in developing countries in the light of their present struggles against colonialism.

Another point that emerged from the planning discussions was the possibility of using other resources in the training programs. Another was consideration of other teaching methods besides lectures and discussions. For example, a wide variety of films was available, especially from the Canadian and British High Commissions. From lists of these, films were selected to be used as regular parts of the training program. Additional films were purchased by the Department, and some were donated by the Colombo Plan and the Asia Foundation.

While most of the films depicted standards and customs of the country in which they were produced, the transition of the principles they illustrated to the customs of Ceylon was easily made through discussions before and after the showing. The psychiatrists were particularly helpful in these discussions and regarded such well-known films as "The Feeling of Dependency," "Roots of Happiness," and "The Quiet One" as especially adaptable.

The Department's library of professional and technical books was also expanded. Lists of all books, including recent acquisitions, were circulated to the staff and the books made available on loan.

Other training programs established included a course for all the staff of the Department's institutions and a series of workshops for the heads of the voluntary institutions. In addition, arrangements were made for the chief probation and child care officers to participate in an administrative seminar given by a Colombo Plan expert.

The week-long workshop for all managers of voluntary institutions was devised as a step toward clarifying the relationship between the Department of Probation and Child Care Services and the voluntary agencies. The Department fulfilled a licensing function in regard to these institutions but the standards established in law were low, and the institutions had full say over admission and other institutional policies. If the children who were admitted met the definitions of eligibility, a grant-in-aid from public funds was paid by the Department. Although the grant was low by standards prevailing in Western countries (amounting to approximately $5.25 per month per eligible child), it provided a major part of the maintenance cost of the institution and paid all expenses of some. The Department by law also had an inspection function, with two members of the central office staff assigned to this duty.

The workshop was focused on common problems in institutional management, with the intention of providing program ideas and suggestions on child care which the managers could then bring back to their own staff members. While reluctance and misgivings were expressed by some of the managers at first, a goodly number turned out, and considerable participation was evoked. Soon requests were received for similar workshops elsewhere on the island.

Eventually it was possible to establish these workshops on a fairly regular basis throughout the country. The chief probation and child care officers took responsibility for organizing the sessions in their respective districts, drawing on the central office staff for consultation and on the institution heads as speakers, discussion leaders and the like. At every workshop, at least one psychiatrist presented material on the dynamics of the growth process. For the majority of the institutional workers, the workshop experience was their first opportunity to meet one another and to speak of their problems, their hopes, and their experiences. It was also their first opportunity to work with the Department in a joint effort to enhance the well-being of children.

As the members of the administrative staff became better acquainted with the voluntary institutions and their personnel, they began to see that if the standards of child care were to be raised, the institutions would have to move out of their purely custodial phase and into more dynamic and meaningful programs. They also began to see the need for helping the institutions regard themselves as instruments for strengthening rather than weakening family ties, an ideal well in accord with the culture's extended family system. To accomplish this end would mean helping the institutions to reexamine their goals, to look closer at admission policies, to concern themselves with the child's parents or relatives while the child was in the institution, and to extend services to children after they left the institution. These objectives evolved as the administrators observed the workshops and as the Department officers attained greater experience in administering the Department's own institutions and in integrating the work of the field and school staffs.

One opportunity to consider the question of the institution's relationships to the child's family arose in a discussion of the institutions' programs during

Left, child care workers play with some of their charges in a receiving home for abandoned children in Ceylon. *Right,* some boys in one of Ceylon's "certified schools"—training schools for juvenile delinquents—help to construct a new building for the school. In Ceylon both types of institutions are operated by the Department of Probation and Child Care Services.

school holidays. When asked to describe their holiday programs, most of the institution managers reported that they sent nearly all the children to the homes of parents or relatives during those periods. Why then, they were asked, can these children not live permanently at home? The answers were varied: in some instances, the parents could provide only temporary arrangements for the child for short periods of time; in others, sending the children home involved risks for the child; in still others, the managers did not know anything about the child's home, especially if the parents or relatives lived some distance from the institution. This led to discussions of whether the institution had a responsibility for finding out the facts, what the best ways to do this might be, and how the ties between the child's family and the child could be furthered. During these talks, evidence of glimpses of new dimensions in child care began to appear.

Another problem frequently discussed in the workshops concerned children who did not have any relatives to whom they could turn when they were discharged from an institution. The discussion revealed that in some instances the children just "drifted away" when they had finished a certain level of schooling; the agency did not know what happened to them. This problem was discussed within the larger question of whether the institution had a continuing responsibility for a discharged child.

The suggestion was made that the employment of a graduate of the Institute of Social Work in Ceylon would be helpful in dealing with this problem. The discussants showed considerable interest in what a social worker on an institution's staff might do in strengthening family ties, in learning of changes in family situations, and in preparing the child for return to his own home. They also seemed interested in the possibilities of the social worker's assisting children who had no relatives to adjust to the world outside the institution, but they pointed out the difficulties of finding places for these children to live and the lack of employment opportunities for them. This led to a suggestion that the institution might have a joint program with the Department to establish a service home where such children could go until they were able to stand on their own feet emotionally and economically. Details of this plan were being studied at the time of the consultant's departure, although the employment of an institutional social worker had not yet materialized. The institutions were obviously beginning to examine their role and function in a broader light.

The voluntary agencies were also helped to see the broader perspectives of their task by being provided opportunities to visit and observe at one of the Department's three receiving homes, where emphasis was always kept upon the welfare of the child, with reference to his own family, if possible. One of these homes had been established in each district to provide a temporary home for children found wandering along the roadways, who had been deserted, exploited, or abandoned, or whose parents sought shelter for them. Responsibility had been given to the field staff for admission, study, and placement. While plans for these receiving homes were well underway before the consultant's arrival, the consultant helped in selecting and training the staff and in developing the program.

Whenever possible, a social study preceded admission of the children to the receiving home and, if the parents were experiencing a crisis, the children were kept in the home until the crisis had passed, with the field officer meanwhile assisting the parents in their attempts to solve their problems. In instances of children born out of wedlock, adoptive parents were sought if this was deemed the best plan for the child. For some children, usually older children, institutional care was decided upon as the best solution and arrangements were made for this care to be given by selected voluntary institutions.

Some Unmet Needs

A rather serious gap in the coordination of services and resources was revealed during a visit by the consultant to a small voluntary convalescent home for children discharged from the tuberculosis hospital. The institutional personnel were finding it difficult to return some of the children to their homes when they had recuperated for the children had, in effect, been abandoned. The usual reason given for abandonment was the parents' feeling that the institution could offer their child superior care.

Such a problem afforded opportunities to discuss parent-child relationships with the institution's staff, to help the agency workers understand what the separation from the parent meant to the child, and ways that might be worked out so that when children did return home they would not suffer a relapse. Films, such as "Roots of Happiness" and "Palmour Street," were most helpful in such sessions. While a program of parent education was more than the small institution could undertake, especially since the children came from homes located throughout the island, the possibility of employing an institutional social worker to have responsibility for returning the children to their own homes was carefully explored with the institution's board.

A more complete solution to this problem and one with a preventive focus would involve use of the islandwide health department with its visiting nurses, community development resources where available, and such resources as are provided through CARE and UNICEF to work with families for the better care of children. There were some expectations that the Department's field staff would provide stimulus in the communities in which they worked to coordinate the various resources available, but the increasing caseloads, lack of community organization skills, and other factors prevented their realization.

Such efforts are also needed to combat the development of handicapping conditions such as blindness which result from malnutrition. The writer vividly remembers being shown through the children's ward of a government hospital by a highly skilled and knowledgeable Ceylonese pediatrician. The ward was full of blind and half-blind children and the pediatrician deplored the fact that he could do little in the way of prevention.

The question might be asked as to why, with the resources of international agencies available and with an islandwide health service (which makes shark-liver oil available without charge), such instances of preventable blindness in children occur. Part of the answer lies in the fact that the newly emerging nation has not had time to "catch up" with all the problems which are coming to light. Another part of the answer lies in the remoteness of some of the villages from the agencies' services and particularly of the living quarters of the plantation workers.

Many of the tea workers who live in these remote areas are illiterate, stateless Indian Tamils, a minority group which comprises about 10 percent of Ceylon's population. They lack understanding of the danger to children in such illnesses as diarrhea, and their children do not have proper care while the mother and older siblings work. Such a problem might be tackled with real success by a technical aid agency such as the Peace Corps.

In many discussions the consultant suggested foster homes as a possible child-care resource, but the proposal met with doubts about the feasibility of foster family care in the Ceylonese culture. While the practice of taking care of relatives' children for short or long periods of time is widely practiced, to accept money for this would be unthinkable to a Ceylonese couple. Some experiments were made in the use of foster homes and some of them burgeoned into institutions. A few, however, were successful.

A discussion of the possibility of foster family day care as a substitute for institutional care for some children evoked expressions of interest. If developed, this type of care might well be the opening wedge for a broader program of foster family homes. In view of the great importance given to the extended family in Ceylon, the values of foster home care would probably meet with acceptance if more widely demonstrated. Such demonstrations, however, would have to be instigated by a worker who firmly believes in this type of care.

Some General Observations

There is in developing countries an immediate need to strengthen existing services and to establish new programs as children are recognized as an important part of the population and as new changes have to be faced in the developing society. The pace that a foreign consultant must choose when caught between the anxiety to "catch up" and to hold back for fear of further dislocations is not ascertainable by any rule-of-thumb. It must be dictated by pragmatic considerations.

The consultant must be flexible. He must also have political know-how, but he cannot operate by the dictum "persuade or perish." Instead, he must present possible alternatives or fresh values. If they are acceptable and prove workable in the particular culture, well and good. If they do not, this too must be acceptable to him as long as those to whom he is offering consultation have made the choice between possible alternatives. Where the step proposed is accepted and shown to be workable, the rate at which change will take place will be determined by a number of factors, among which are the skill and the knowledge of the consultant in fulfilling his role as a change agent.

What the effectiveness will be of the measures introduced in Ceylon during the 2 years of the child welfare consultant's visit cannot as yet be evaluated. There is some indication, however, that children are beginning to be regarded as distinctive personalities with individual potentials for growth and development, and this, of course, is the beginning of "welfare." Ceylon, like the other nations of the world, needs a citizenry which can function at its best in order to face the many problems of tomorrow.

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[1] Yankauer, Alfred: Intercultural communication in technical consultation. *Children*, September–October 1959.

MENTALLY RETARDED TEENAGERS IN A SOCIAL GROUP

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CHILDREN LEARN to live with others only through experience. However, the retarded child is often caught in a vicious spiral that is negative and limiting to his social development. The lack of social experiences leads to social retardation and ineptness in chronologically appropriate social skills, accompanied by emotional difficulties arising from feelings of rejection and deprivation; and the lack of social skills further limits the opportunities the retardate has of participating in social experiences.

Mentally retarded children must be taught many things which normal children learn spontaneously or incidentally. Often they must be taught to play and to be helped in developing creative qualities that give them fun and pleasure. When this has been achieved the retardate can gain the same satisfactions from participating in social activities as other people. These satisfactions derive from: (a) being recognized and accepted in the group situation; (b) a sense of accomplishment in activities in which he is successfully interacting with his peers; (c) the experience of self-expression, especially when making positive contributions to the group's activities; (d) the enhancement of self-esteem; (e) and the feeling of "belonging."

To give young retardates these opportunities, the New York City Chapter, Association for the Help of Retarded Children has conducted a group work, recreation, and camping program for mentally retarded children, teenagers, and young adults for the past 11 years. At first the program was directed by a social caseworker, but for the past 5 years it has been the responsibility of a professional social group worker who spends full time on the job.

The program was developed on a decentralized basis in whatever facilities were available in neighborhoods throughout New York City—churches, synagogues, schools, park buildings, housing projects, and veterans and union halls. It includes groups of elementary school-age children, teenagers, and young adults. In placing individuals in the groups, chronological age, previous social experiences, and social adequacy and functioning are considered together. Trained group workers are used as group leaders, assisted by a nonprofessional person of the opposite sex who may be a staff member or a volunteer.

The purpose of the program is to provide:

1. A medium of enjoyment for mentally retarded children and youth.

2. A setting which will aid them in social adjustment—one which provides a small, intimate, face-to-face experience with others of the same age, including members of the opposite sex.

3. Experiences to help them develop simple, useful skills that they can carry over to the home, to the community, and perhaps to employment.

4. Experiences to help them accept themselves and the limitations imposed by their retardation, as well as to utilize their capacities to increase their feelings of self-worth.

5. A means of freeing parents for a few hours weekly of the supervision of the retardate and of helping them to carry over into the home and community attitudes that will promote increased independence in their children.

One of these groups is the Queen's Teens—a coed social club of adolescent retardates 12 to 15 years of age, one of 12 such groups throughout the city. The group meets each Wednesday evening from 7:30 to 9:30 p.m. in the basement recreation room of a large cooperative housing project in a middle-class neighborhood in the borough of Queens. The location of the meeting place is far from ideal—neither having the facilities of a community center nor offering potential contact with other children, but it is adequate.

The membership of the Queen's Teens reflects the socioeconomic character of the middle-class neighborhood.

The New York City Chapter, Association for the Help of Retarded Childred provided the overall program structure, supervision, and administration, which in this instance included the paid male leader, special interest and holiday programs, and program supplies. A women's auxiliary affiliated with the New York City Chapter supplied two female volunteers a week, refreshments, and occasional special program needs.

Composition of Group

Members were referred to the group by the New York City Chapter after their application had been processed through intake. The intake process included an interview by the director of group work services with the young person and one or both parents at the office of the Association. Before the interview, information about the child's development and his family situation was obtained from school records, clinic material, and other sources. Criteria for membership in the Queen's Teens were: (a) membership of the parents in the Association for the Help of Retarded Children; (b) chronological age, 12 to 15; (c) the ability to participate at the level of the group; (d) the capacity to derive benefit from the group experience. Eligibility in relation to the last two criteria was determined only after the teenager had participated in several group meetings. The final decision was made by the Chapter's director of group work services, the leader of the group, the parent, and the teenager himself to the extent of his ability to understand.

Within the 8-month period on which the observations in this paper were based, a total of 19 teenagers were referred to the group. While the aforementioned criteria identified this as a "formed" group, it contained some elements of a "natural" group in that its members referred to it some of their classmates from school. (Most of the young people attend special public school classes for the retarded.) The group became stabilized at 10 members, with an average attendance of 8 or 9 youngsters at each meeting. Of those who did not continue: one was found by the leader to be functioning at a higher level than the group; another chose not to come because he himself felt the group was too young for him; one child had no means of transportation; three teenagers never attended because their mothers were not interested in the group after visiting the meetings; one youngster was asked not to come because his attendance was irregular, averaging less than once a month, and his behavior when present was disruptive to the group.

The teenagers who remained in the group came regularly to meetings not only because of interest in the group and the program, but also because the parents assumed the responsibility for bringing them. Only two of the members lived within walking distance, the others being scattered in a 5-mile area.

The children's IQ's ranged from the forties to the seventies. This information, however, was found to be of little use in planning recreational activities for the group, for it did not give any indication of the young people's ability to function in a social group. What was of greater importance in program planning was the youngsters' ability to relate to adults and peers, to work and play with others, and to use program materials. At present there is no meaningful measure of this type of ability available.

A scale rating the children on the nature and extent of their social functioning and adequacy would be of great help in the selection and placement of individuals in social groups. There appears to be a distinct difference in the individual's intellectual level, his chronological age, and his social functioning. We found that the child who had previous positive social experiences functioned better in the group, regardless of his intellectual level.

Program Structure and Content

In programing for the "QT's" the emphasis was on the provision of both social and learning experiences which to the participants would be regarded as exciting, satisfying, and full of fun. The group worker and the volunteers worked with the youngsters in an uncritical and supportive manner in regard to their participation while attempting to further their development in the areas of self-care, use of program activities and materials, interaction with their peers and adults, and self-expression.

The group was called a "club" on the assumption that the term would have status significance to the adolescents. The group worker took the responsibility for planning a program and modifying it to both the group's and the individual's readiness at the time of the meeting.

The activities relied upon were the kinds common to recreational groups—loosely organized games, square and folk dancing, singing, arts and crafts. In addition, activities involving the retardate in learning a functional task related to everyday living were included and were especially popular. These activities included (1) short trips in and around the immediate community; and (2) preparation of refreshments. The trips included shopping in the supermarket, buying sodas and cakes in a local cafeteria, walking to the park, riding the subway, and eating lunch in the automat. The supermarket and cafeteria trips provided the basis for later role playing as waiters, clerks, and customers.

The volunteers were responsible for selecting and bringing refreshments that the children could prepare for themselves. They started with caramel apples and popping corn and moved to chocolate and tapioca puddings, pizza pies, vegetable salads, hot dogs, and stuffed celery. The parents were especially impressed by the skill their children developed in these activities.

Special projects—puppet making, mad-hatters ball, birthday parties, and celebration of holidays—were also successful.

Each 2-hour meeting was planned to allow for individual participation both in choosing and leading activities. The breakdown and approximate time involved in each session were as follows:

1. **Premeeting** (15 minutes). While the group was gathering for the evening, the teens moved about the room playing with various games and equipment. During the period of initial development these were set up before the young people arrived. Later the young people helped the worker to get the room ready for the evening.

2. **Meeting** (15 minutes). The group worker would call the members to come and be seated around a table. The "meeting" opened with a set of seated circle games used regularly from week to week. After this opening the group worker asked the members to tell about their individual experiences during the week and encouraged them to talk about their other interests, with the purpose of engaging the individuals in informal conversation, allowing for and stimulating interaction between the members themselves and the adults. In addition, the evening's activities were planned at this time.

3. **Major activity** (30 to 45 minutes). The theme of the evening was developed and carried out during this period—parties, walks in the snow, games, or arts and crafts.

4. **Refreshment period** (30 to 45 minutes). While the members ate the refreshments which they had helped prepare, the group worker and volunteers engaged them in individual informal conversations. Afterwards the members helped in cleaning up.

5. **Closing period** (30 minutes). The program ended with singing, dancing, or a game or two. Then the group worker made an announcement about the following week. Before going home the young people helped to put away the program equipment and made a game of folding and stacking the chairs. The group worker and volunteers always greeted the parents as they arrived to pick up their youngsters.

Some Observations

From the experience with Queen's Teens one could draw some general observations on group work with the retarded:

1. *Retardates, like other individuals, can be expected to react differentially to group experiences.*

Contrary to a common belief that retardates tend to be passive and overconforming, the group worker found evidence among the Queen's Teens of a normal range of behavior. For example:

> Mary, Jane, and Alice can be counted on to do whatever the group wants to do or what the leader suggests. They always vote as the others and never do anything on their own or in disagreement with the others. They seem too insecure to express their own wishes. Yet, when a decision was left up to the three of them and nobody else, one of them came forth with a suggestion that the others followed.

* * *

> In contrast, Bob, Jim, Dick, and Lottie act completely independently, participating in the group activities only when they want to. They seem to regard the meeting as an opportunity for individual self-expression. Jim, for example, entered the room one evening saying, "Leave me alone tonight; I don't want to play." He then moved away from everyone and began walking around the room by himself. When he got tired of doing things by himself, he came back into the group and participated in activities with the others for the rest of the meeting.

Thus, some of these young retardates found in the group experience a chance not only to do things with the others but also to express their individuality by choosing when and where they would participate. As long as an individual's expression of independence was not disturbing or limiting to the others in the group activity, it was respected and encouraged by the leaders.

2. *The individual's needs take precedence over the group's needs.*

The group worker found that often the actions of an individual were more important to deal with than to keep the group activity going—for example, when Larry threw a tantrum because he was not

Group dancing is one of the activities enjoyed by the Queen's Teens, a social club for retarded adolescents in New York. Here they participate in a dance with their group leader.

allowed to dominate the group in playing a game; or when Bob kept running around screaming.

However, in such instances, after the group worker stopped the group's activity in order to deal with the individual he would involve the entire group in the discussion of the situation. In that way the problem of the individual was woven into the program of the group.

Often independent actions were expressive of creative urges or moods rather than the acting-out of hostility or anxiety. Thus, Bob rushed to the piano and banged away loudly while the group was singing *She'll be Coming 'Round the Mountain*, and at another time Jim listened quietly to a phonograph record while the group played tag.

At such times, the group worker adapted the group's activity to involve the independent individual in a positive and encouraging manner: With Bob—"Let's join him at the piano and sing while he plays," applauding his efforts when the song ended. And with Jim—"Jim, will you help us play musical chairs by turning the record on and off while we play?"

In both these instances the individual moved with the group into the next activity after such an approach.

When it was not possible to adapt the group's program to an individual's independent behavior, the individualist was asked to stop what he was doing but with the condition that later on he could come back to finish what he had started. In essence the group worker was saying that he thought the individual was as important as the group.

3. *Program is planned to provide individuals with opportunities to experience success.*

It was assumed that a successful experience in participating in the group's program would loosen the individual's inhibitions and give him the security to participate in the program more fully. Therefore, games were modified so as to give everyone a chance to win. Arts and crafts projects were always admired if the individual himself liked what he produced. The group worker made a practice of informing each parent—in front of the child—that their child had done quite well that night in the group.

In playing "choosing" games sufficient control was provided by the group leaders to assure each teenager a chance to be both chooser and chosen.

4. *Expectations of the level of an individual's performance must vary in relation to the intellectual, social, and emotional aspects of behavior.*

Among the Queen's Teens the group worker assumed an uncritical role in relation to a child's intellectual performance. However, when it came to cleaning up, putting on coats and hats, getting chairs, he was more demanding. The level of expectation of course differed for each child, according to the child's physical and motor coordination. When the child did not respond as expected, the issue was dropped and taken up at a later time when the child seemed more cooperative. For example:

Laura who is almost blind was given a record to place upon the phonograph. (Her mother had mentioned earlier that she had never done this at home.) Because of a spastic condition, Linda had very poor motor coordination, but she was able to get herself to the record player, place the disk on the turntable, and almost get the needle in the right groove. She exhibited great pride in this accomplishment.

* * *

Alfred, an obese and overprotected child, was afraid of going out into the snow. He said he would catch cold or he would slip and break a leg. It was a difficult task to get him outdoors—one which involved seeing him through three tantrums—but after this was accomplished, he became more amenable to other trips away from the building.

5. *Group activities must be carefully selected to suit the functioning level of the group.*

For the Queen's Teens the group worker chose familiar games which the young people knew and liked. New games were also introduced but modified to suit the group and allow for successful play.

Among them was a clapping rhythm game that is popular with adolescents generally. It took 3 months for the group to learn this game, but they did learn it and liked to play it so well that they made it part of the opening portion of each meeting. Regardless of the type of activity, the presentation was always geared to the level of the group members in order to minimize frustration and provide for satisfying participation.

Group Worker, Individual, and Group

While the retardate benefits from experience in a social group, he evidences a slower than normal development in social skills. It is up to the group worker to remain "enthusiastically patient" during the long, slow process of gradual improvement. While enthusiasm and warmth are important factors in work with any group, they are even more important in work with retardates. Parents and teachers of retardates, because of the demanding nature of their responsibilities, may at times have their enthusiasm worn thin. Yet, like everyone else, the retardate needs people around him who are stimulating and enthusiastic.

In spite of the necessity to suit the activities to the group, it is not necessary to "talk down" to the retarded. The leader talks to them in the same manner as he would to other adolescents.

On the other hand, because the retardate is limited in social experience, it is necessary for the leader to have a highly structured program plan that remains similar from week to week. As the participant becomes more accustomed to the pattern, he begins to anticipate what will come next, deriving much satisfaction from this accomplishment.

Experience with the Queen's Teens, and other groups of mentally retarded formed by the Association, indicate that while individuals change within the group, there is some group movement toward higher levels of activity. Individuals, however, do learn to participate in activities with their peers, and in social adequacy appear to move closer to the social expectations of their chronological age.

The Queen's Teens is now in its third year of existence. In this third year we have noted some movement toward subordinating individual needs to that of the group; in the ability of the group to carry out a short "business" meeting; in the individual's ability to take on more responsibility for his own behavior and for planning together with the other members; and in the ability of the group leader to lessen the active nature of his role in the knowledge that the group could take more responsibility in regard to simple activities.

The Association, in extending its program to serve additional groups in different parts of New York City, has found that variables such as previous group experience, religion, culture, and socioeconomic and minority group status have an impact upon a group experience for the retarded adolescent, although there are still many unknowns in this regard. In some families of low socioeconomic status, retardation of a child may be only one of the many other serious problems affecting the family and is not therefore always perceived as a crisis situation, as it is apt to be in middle-class families. Many retarded adolescents in such families, who are in the higher functioning range of retardation, seem to have much in common with their normal contemporaries and to have acquired some social skills in the process of daily living. Barring gross stigmata, their intellectual deficit or perceptual difficulties are the most obvious signs of their retardation to the group worker.

In the group situation, these young people need a great deal of help in planning and following through on responsibility for program development, as did the Queen's Teens, and again structured program is helpful. However, relationships are formed more readily between the members who are of the same socioeconomic or cultural background in view of their having similar experiences in school and in the neighborhood. The members also relate more easily than those in such groups as the Queen's Teens to other young people who use the group service agency, as they generally share a similar background. These young retardates also seem to have greater interest in energetic activities, especially athletics, and less fear of risking injury. They have had more exposure to group experiences with their peers, both retarded and normal. This is probably due to less maternal overprotection.

As additional experiences are accumulated with such groups and analyzed, the findings may not only help to refine social group work method with the mentally retarded, but bring to light additional information about social development patterns and the use of leisure time and about what kind of interaction patterns occur between retarded and normal individuals as well as between retardates.

THE PHYSICIAN AND PARENTS OF THE RETARDED CHILD

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DURING the last 12 years much progress has been made in assessing the potential ability of the retarded child, and applying this toward the development of community programs to help him realize this potential. Sparked by the National Association for Retarded Children and given major impetus by programing and funds from the Children's Bureau, a mushrooming of multidisciplinary clinics devoted to diagnosing and planning for the retarded child has occurred throughout the country. These clinics examine the child from medical, social, psychological, and educational points of view, interpret to parents the nature and magnitude of the condition, and attempt to set up a comprehensive plan for future management of the child.

However, many children are taken long distances to clinics for the mentally retarded by their parents, and after confirmation of the diagnosis return to their homes where professional persons who have specialized in work with retarded children may not be available. Thus it remains to the family physician or pediatrician to counsel and advise the parents as their mentally retarded child grows older.

What can the family physician or pediatrician do when presented with a child obviously mentally retarded or one suspected of being so, if in his community such specialized services are not available? Does helping the parents and child require a vast body of information which he cannot hope to have at his command? Must he take extensive refresher courses in mental retardation to answer the inevitable and seemingly interminable parental questions about the child and his future?

When the retarded child is passing through the first few years of life, it is most difficult for any person to answer the questions of ultimate prognosis uppermost in parents' minds. Nevertheless, these early years are crucial for the child, since during this period of life his basic personality patterns begin to emerge. If in addition to a delay in development the retarded child must cope with a liberal dose of parental anxiety and feelings of helplessness, his entire adjustment can be channeled into areas of behavioral abnormality which will lead inevitably to early institutionalization.

The pediatrician or family physician who sees retarded children can and must play an important role during these early years. By virtue of his training and experience in normal child development, he can contribute to the normal personality development of the retarded child, especially if he already has an established relationship with the family and has gained their respect and confidence. Through his knowledge of the home atmosphere he can anticipate problems that may arise and can give the parents many practical suggestions for managing the child. Many parents who, because of their feelings of guilt and anxiety, would not be able to seek help from a child guidance clinic or social agency can lean on the strength of their family physician or pediatrician, and thus accomplish many changes in their behavior toward the child even though they do not gain any real insight into their own feelings. Direct suggestion, even when it conflicts with basic parental feelings, can often be accepted.[1]

The birth of a child is a momentous occasion in the life of a family. Long before birth, parents idealize the child and make elaborate and often fanciful plans for his future. Many parents see their child as an extension of themselves and as an opportunity to live out their own fantasies and wishes. While many normal children do not live up to the often unrealistic expectations of their parents, who therefore must gradually relinquish their cherished plans, parents who receive a diagnosis of Mongolism at their child's birth or mental retardation early in life have their dreams and fantasies brought to an abrupt end. Thus, when a diagnosis of mental retardation is made, it is the parent who suffers a blow rather than the child.[2]

Consequently parents who seek help for a retarded child are usually in a state of heightened emotions. They frequently expect and fear the worst, and are already calling forth the usual feelings of shame or guilt which people suffer if something goes wrong in connection with the birth process. One recent study of the initial subjective reactions of a group of parents whose children had been diagnosed as mentally retarded has shown that about half expressed feelings of rejection toward the child associated with shame or guilt, and a large proportion of the others worried about reactions to the child of their other children, relatives, and friends.[3] Some parents are unable to overcome their frustration and disappointment at the child's inability to attain their ambitions for him; he remains a source of irritation to the family and may even precipitate its disruption.

Diagnosis

When the physician first suspects Mongolism in a newborn infant, he may want to seek confirmation of his diagnosis by consultation with a colleague. His next step must be to interpret the diagnosis to the parents during the neonatal period or shortly thereafter, preferably to both of them together. After the initial shock has subsided, the parents will inevitably deluge him with questions concerning the "why" and "how" of it, and having to do with the child's chances for health and adjustment in later life. In addition to talking these problems over with them in considerable detail, he may find that providing them with a copy of the booklet "The Mongoloid Baby," [4] which answers the questions most frequently asked by parents on this subject, is a great help to them.

In the case of the nonstigmatized retarded infant the diagnosis is usually one gradually suspected, frequently not until after the child is a year old. The physician then has the difficult task of deciding whether a developmental aberration is a physiological variant or is, in fact, true mental retardation. Perhaps the most pertinent finding in early diagnosis is the observation, as recently noted by Illingworth,[5] that the child who is mentally retarded from birth or shortly after birth *is behind in all fields of development* except occasionally in the gross motor field. On the other hand, the child retarded only in a specific field of development (walking, talking) may represent only a physiological variant and should not be considered mentally retarded unless his further course of development so indicates. When a suspicion of mental retardation arises, the physician should seek the services of a qualified psychologist to confirm his impression or refer the child to a multidisciplinary evaluation clinic if one is available.

Without entering into the controversy of the reliability of infant testing as a predictor of future intellectual potential, this author is in agreement with those who believe that the great majority of infants whose development is found to fall *within the mentally defective range* (Developmental Quotient less than 70) in the first 2 years of life are likely to be found to be mentally retarded in later years.[6] Certain premature infants of low birth weight, infants with a history of "maternal deprivation," and those with chronic debilitating physical disease may be important exceptions. When there is uncertainty, psychological testing repeated 6 to 12 months after the initial tests may clarify the diagnosis.

However, when a diagnosis of mental retardation has been made and interpreted, the physician's work has just begun. Many physicians do not relish the task of helping parents with retarded children because they feel that there are serious gaps in their knowledge of the growth and development of the retarded child. But they do have considerable knowledge of *normal child development* and can bring this to bear most satisfactorily on the management of the *abnormal child.*

Telling the Parents

When the physician tells the parents about a diagnosis of mental retardation, he frequently meets with denial, and then sometimes becomes the target for parental criticism and hostility. This is particularly true if he presents the diagnosis only, giving no suggestions as to how the child should be handled or what kind of plan should be made for him. In a recent study, Koch and his co-workers [7] have commented on the frequent dissatisfaction of parents with the way pediatricians and general practitioners deal with the problem of the mentally retarded child and on the parental bitterness toward what they regard as the cursory nature of the examination and presentation of facts. In the case of the non-Mongoloid child, who seldom exhibits recognizable physical abnormalities, parents and physicians frequently arrive at a suspicion of mental retardation together. However, the parents often become anxious long before the physician, who sometimes retreats behind the phrase "he'll grow out of it." When the diagnosis is eventually made, the parents often express animosity toward the physician who did not listen to their fears.

Some physicians react to the diagnosis of retardation in a child with an abrupt recommendation for institutionalization. While this may be indicated in some situations, the recommendation is a far-reaching one and should be made only after such factors as attitudes of the parents toward the child, the social background of the family, the welfare of the child's siblings, the economic status of the family, and the availability of satisfactory institutions have been taken into account. Such a recommendation is often made without considering the possibility that the retarded infant may profit considerably from the mother-child relationship in the first years of life and that his presence in the family is not likely to interfere seriously with the normal emotional development of older or younger siblings. Studies such as those of Schipper[8] and Saenger[9] have emphasized the good adjustment of many retarded children and young adults living with their families.

Helping parents face up to the diagnosis cannot be done quickly. For example, at the District of Columbia Clinic for Retarded Children, which provides continuous followup services to retarded children and their parents as long as they are requested, the initial interpretation may take as long as an hour to an hour and a half. During this time the parents are encouraged to express their feelings of hurt and disappointment as well as to ask any and all questions concerning the child's future potential. And the clinic's services to parents do not end with the initial interpretation. Many parents receive brief or continuing social casework in order to work out their feelings; the child development specialist sets up home training regimens;[10] parents are seen in groups so that they may explore their mutual feelings toward their children and how to deal with problems of behavior and development;[11] brief psychotherapy is made available to selected children; and a variety of other services are given. Parents are encouraged to contact the clinic at any time the child exhibits a developmental crisis or at any time educational or training plans are indicated.

Thus, the actual evaluation is both a learning and a therapeutic experience for parents since they have a chance to air their views of the child's deficiencies and to compare his development with the development of normal children. Rarely after this is a parent unable to realize, at least intellectually, that his child is retarded.

However, we have found subjective parent reaction at the time of interpretation at the clinic to vary from complete acceptance of the clinic's findings and whole-hearted cooperation in planning for the future life of the child to one of complete rejection and subsequent "shopping" to other agencies. Some parents persist in their fantasies that the child will "grow out of it" and that the retardation is not as severe as the clinic has found. They frequently use the interpretation session to criticize one or more aspects of the evaluation and to ignore many of the findings.

Counseling and Time

Curiously, during this often very emotional session, parents seem to be directing their comments to the world at large rather than to any specific clinic member—their reason tells them what their feelings will not allow them to believe. Particularly is this true of fathers, who frequently cling to the hope of future normality. It is at this time that counseling, whether given by a trained social worker or by any other professional person with the ability to listen, sympathize, and respond wisely, is most valuable.

It is this author's impression, however, that even following a careful evaluation and continuing followup service by skilled personnel, the most important factor in the ability of parents to plan realistically for their child is *time*. Many parents, while initially rejecting the diagnosis, after a period of time in the home, where they can appraise the child and compare him to his normal siblings and playmates, are able to see and to say that their child is abnormal. An important element in the effects of time is the fact that the retarded child of preschool age *passes through the same stages of development as do normal children*, even though at a slower rate. For instance, when a parent has been able to observe his child's attainment of a particular self-help skill such as toileting, he is able to say to himself that the problem is not after all hopeless. Being more hopeful, he is at the same time more able to admit that his child is retarded.

Many parents who have initally rejected the diagnosis of mental retardation return to the clinic a year or so later proudly demonstrating the recently learned skills of their child. Some parents who are unable or unwilling to talk of their disappointment or guilt at having produced a retarded child are able to focus on his accomplishments and plan ahead for his future life. It is most important, therefore, that the "pot be kept boiling" during the early developmental years when the child who ultimately will have great difficulty in school can be compared more favorably with his normal siblings.

Anticipatory Guidance

How different is the retarded child from normal children in the preschool years? In one sense he is no different. For, while his rate of neuromuscular development is delayed, the stages through which he passes are the same. As the normal child does, he will sit before he crawls, crawl before he stands, and stand before he walks. At the time of walking he is most likely to respond to attempts to toilet train him. Thus, the physician with even rudimentary knowledge of child development can give the parents "anticipatory guidance" by applying this knowledge to interpret the next step in the training of the child. He can supplement his interpretation by giving them easily obtainable and readable booklets on normal child development[12, 13] which deal with many of the needs of parents of a retarded child in the preschool years.

The frequent contacts with parents and child provided by ordinary well-child visits provide a natural setting for discussions of developmental problems. In these, the physician need only provide continuing sympathy, support, and encouragement to the family. While advice should be geared to the level of parental anxiety, it should always be presented in terms of normal stages of development. The parent can compare his child's progression in these stages with those of normal children, especially if the child has older, normal siblings, and see that after all this is first and foremost a child—a handicapped child, to be sure, but a child nevertheless.

The services of public health nurses are invaluable in helping parents of retarded children, especially when they visit the home and provide practical advice and demonstrations of how to set up self-help routines—self-feeding, toileting, dressing. This not only helps the mother in managing the child but also indicates that someone is interested in her problem and is willing and able to help her meet it. Information contained in such booklets as "The Mentally Retarded Child at Home"[14] also proves quite useful in this respect.

In talking with the parents it is not necessary to use scare words such as "brain damage" or highly scientific phrases which the parent may misinterpret or not understand. Parents should be encouraged to watch their retarded child grow and to enjoy him just as they would a normal child, treating him in terms of his mental age and allowing him to progress at his normal rate of speed. "Behavior problems" encountered in the preschool period are most often characteristic of the developmental stage for the child's mental age or a reflection of abnormal pressures applied by parents who are treating him as a child of his chronological age. The younger a retarded child when diagnosed and the earlier the physician is able to help the parents set up simple regimens in the home, the greater is the likelihood of a child's developing a healthy personality and being able at school age to adapt to and enjoy the school setting for which he is qualified.

The occasional hyperactive, distractible, retarded child whose retardation has an organic basis presents special problems in management by virtue of his speeded-up pace of living and requires a modified approach involving firmness and limit setting, techniques often alien to many parents. The paradoxical effects of such central nervous system stimulants as dextroamphetamine and methylphenidate are frequently very useful for quieting the hyperactive behavior of such a child.

During his contacts with the family the physician must continue to remember that the parents' acceptance of a child's mental retardation will be gradual. Whether or not it proceeds at the rate he thinks it should, the important thing to watch is whether the parents are following through with plans for training in self-help skills and are treating the child in a way that will foster a healthy personality development. Each parent must find his own way to this acceptance, and there are as many different ways as there are parents.

The physician should be prepared to keep his own plans for the child flexible. For example, he may feel that a young child's place is with his mother in the home all day, failing to realize that the presence of a child who remains an infant for a long period of time may be a chronic source of physical and emotional strain on the mother. A substitute mother in a daytime foster family home or day-care center can allow the mother the breathing spell she needs. Should the physician at any time become aware of increasing parental tension or inability to deal with the child in the family, referral of the parents to an appropriate community family service or child welfare agency for counseling or planning for institutional placement is indicated.

As the child grows and approaches the age at which children need group experience, the physician should try to help the parents find a nursery school in the community which will accept retarded children, to help prepare the child for entering a specialized class in the public school. Helping the school-age retarded child more and more becomes the responsibility of the educator and vocational rehabilitation worker as the child grows older, the physician's role becoming one of normal health supervison. With optimal care and training many retarded children as adults become productive members of society, and when they do the physician can look back with pride at his role in fostering their normal personality development in the preschool years.

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[1] Mead, B. T.: Physicians attitudes decisive in treating children's emotional problems. *Feelings*, June 1962.

[2] Werkman, S. L.: Symposium: the physician and Mongolism. *Clinical Proceedings of Children's Hospital of the District of Columbia*, February 1961.

[3] Graliker, B. V.; Parmelee, A. H., Sr.; Koch, R.: Attitude study of parents of mentally retarded children. II. Initial reactions and concerns of parents to a diagnosis of mental retardation. *Pediatrics*, November 1959.

[4] U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau: The Mongoloid baby. CB Folder No. 50. 1960.

[5] Illingworth, R. S.: An introduction to developmental assessment in the first year. William Heinemann, Ltd., London, England. 1962.

[6] ———: The development of the infant and young child, normal and abnormal. E. S. Livingston, Ltd., Edinburgh, Scotland, 1960.

[7] Koch, R.; Graliker, B. V.; Sands, R.; Parmelee, A. H., Sr.: Attitude study of parents with mentally retarded children. I. Evaluation of parental satisfaction with the medical care of a retarded child. *Pediatrics*, March 1959.

[8] Schipper, M. T.: The child with Mongolism in the home. *Pediatrics*, July 1959.

[9] Saenger, G.: The adjustment of severely retarded adults in the community. New York State Interdepartmental Health Resources Board, Albany, N.Y. 1957.

[10] Dittmann, Laura L.: Home training for retarded children. *Children*, May–June 1957.

[11] Anderson, Alice V.: Orientating parents to a clinic for the retarded. *Children*, September–October 1962.

[12] Spock, B.: Baby and child care. (Revised edition, paperback.) Pocketbooks, New York. June 1962.

[13] U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau: Your child from one to six. CB Publication No. 30. 1962.

[14] Dittmann, L. L.: The mentally retarded child at home. U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 374. 1959.

Mental retardation ranks as a major national health, social, and economic problem:

It afflicts twice as many individuals as blindness, polio, cerebral palsy, and rheumatic heart disease, combined.

Only 4 significant disabling conditions—mental illness, cardiac disease, arthritis, and cancer—have a higher prevalence, but they tend to come late in life while mental retardation comes early. . . .

The untold human anguish and loss of happiness and well-being which result from mental retardation blight the future of millions of families in the United States. An estimated 15 to 20 million people live in families in which there is a mentally retarded individual. Economic costs cannot compare with the misery and frustration and realization that one's child will be incapable of living a normal life or fully contributing to the well-being of himself and to society in later life.

From "A Proposed Program for National Action to Combat Mental Retardation," a report to the President by the President's Panel on Mental Retardation, October 1962. (See page 123 of this issue.)

TREATING SCHIZOPHRENIC MOTHERS WITH THEIR BABIES

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ONE of the most interesting pieces of current pioneer medical work in England is being carried out at Banstead Mental Hospital, Surrey. This hospital has a mother and baby unit for the care of schizophrenic mothers admitted with their babies. The unit was opened 4 years ago, following several years' research into the behavior of schizophrenic mothers after discharge from a mental hospital. This research was reported at the Second International Conference for Psychiatry at Zurich in 1957. Contrary to popular belief, it showed that schizophrenic mothers rarely try to harm their children and that the policy of separating them from their babies often causes more difficulties than it solves.

The unit is a small one, taking up to eight patients; the hospital as a whole serves a population of about three-quarters of a million, but this population does not always provide sufficient patients to keep the unit full, so that other schizophrenic mothers are occasionally taken from another area to fill empty beds. Schizophrenic patients have their own particular difficulties and there are some advantages in treating them in a group by themselves.

The patients are either referred by obstetric departments or general practitioners, if the patient has returned home. The unit will accept any mother who has a schizophrenic illness provided the baby is still under 1 year old. The unit is particularly intended for the severely disturbed mother whose management is impossible outside a hospital; about one-third of the mothers are admitted under compulsory orders. The unit, nevertheless, is quite open and there have been no significant difficulties in the management of the most severely disturbed patient.

Physical treatment, particularly E.C.T. (electroconvulsive therapy), and tranquilizers are used vigorously in the first few days after admission until the acute symptoms have subsided. Treatment intensity is then reduced over the ensuing weeks though most mothers receive about 20 shock treatments, and on discharge will still be taking a maintenance dosage of tranquilizer. The nursing staff consists of two trained psychiatric nurses per shift in addition to nursery nurses whose function is to supervise and help the mother care for her baby. Some mothers require no help in this; but a patient in stupor may be able to do very little for her baby for some days so that the nursery nurse may have to take complete charge of the child.

Breast feeding is maintained as far as possible. It has been found that patients can successfully breastfeed while in stupor and also that breast feeding is unaffected by shock treatment and tranquilizers which, if anything, seem to increase milk production.

Structured Environment

The psychiatric nurses are trained to treat each patient as an individual. In general, most schizophrenic patients need a clearly structured environment with fairly rigid rules when first admitted, though this situation is relaxed as the patient progresses until she has full freedom by the time of her discharge. Most patients—even the most severely disturbed—have improved sufficiently to go on weekend leave 2 weeks after admission. The psychiatric nurses also learn that the patient's problems involve her whole family. Therefore, the nurses spend much time in discussions with visitors. Every day is visiting day. Most husbands come daily and other relatives, including in-laws, visit on occasions. Family emotional patterns often become dramatically clear under the influence of a puerperal psychosis in a young mother.

The social worker is expected to investigate every patient's home situation and conduct home followups after discharge in every case. Some patients, however, live too far from the hospital to make this possible. As would be expected, the relapse rate among these patients is much higher than the relapse rate in the patients for whom adequate followup is possible.

In addition to day-to-day discussion of immediate problems, there is a weekly meeting of all the staff of the unit, including doctors, nurses, social workers, and, if relevant, psychologists. In this meeting the staff reviews its total knowledge of the patient and her progress and also the progress of patients who have left the unit.

At times, two children of the same mother—a baby and a toddler—have been admitted. There are serious disadvantages to this arrangement. Schizophrenic mothers have greater difficulty than most in dividing their attention between the baby and the toddler. They have a specific problem in correctly assessing the age and needs of their children, and the presence of two seems to add to this confusion. In general, we feel that the father, or other relatives, can usually make satisfactory arrangements for toddlers and that, in the long run, this is to the childrens' advantage and leaves the mother to concentrate on her baby.

It has been shown by comparison with a control group that those mothers treated with their babies not only make a better recovery, but are less likely to relapse: 100 percent of those treated with their babies left the hospital able to care for their babies, compared with 60 percent of the mothers in the control group who had received treatment from the same psychiatric team but who did not have their babies with them.

The evidence to date suggests that the arrangement is also to the advantage of the baby, who suffers less disturbance through changing hands at the time of the mother's admission and, of course, does not have to adjust to a strange mother when the mother returns home from the hospital. Long-term followup will show whether there are similar advantages to the family as a whole. Certainly, evidence to date suggests that the children in these families are less likely to be disturbed by the mother's illness than the children, for example, of neurotic parents.[1]

The following is a typical case:

The patient was a Belgian woman who had come to England as a girl and married an Englishman. There was no history of mental illness in her family. Before her illness she had been a friendly and competent woman of above average intelligence. She spoke good English and, superficially, had adjusted to the English culture.

The patient had had her first baby in a general hospital where she had suffered considerable anxiety and uncertainty about the behavior expected of her. In fact, she had become so anxious that she had begun to question the behavior of the nurses and whether they were doing the right things for her. She had then been placed in a single room, which increased her anxiety. Finally she had become so "difficult" that she was sent home prematurely lest she disturb other mothers. At this point, in spite of her strange statements and obvious paranoid attitudes, the possibility of mental illness had not been considered. At home she had been unable to sleep, had become progressively excited and confused, and eventually—2 days after her return—had assaulted her husband and had run down the street unclothed. She was admitted to our unit with her baby.

On admission, this woman expressed obvious paranoid delusions—believing that her food was being poisoned, that people were spying on her, and that other attempts were being made to harm her—together with a general paranoid attitude. She exhibited incongruity of affect and thought disorder of a schizophrenic type. She continued to breast feed her baby, and eventually made an excellent recovery on electroconvulsive therapy together with a tranquilizer. She was discharged home after 10 weeks, and 18 months later was discharged from the outpatient clinic. She remains fit and is a good mother.

This woman's husband was found to be a rigid, rather inadequate man, who was extremely upset by his wife's illness and appeared to have no insight into it. On his second visit to the unit, his own behavior was so strange that he was admitted to one of the male wards. He, too, had a schizophrenic episode at this time, which responded to treatment, and he returned to work within a few days; apart from his personality limitations he has given no further cause for anxiety.

As in this case, change of culture or domestic pattern often seems to be associated with schizophrenia following childbirth. The case also illustrates the severe stress experienced by some husbands when this condition occurs. Several husbands have produced overt symptoms themselves when their wives have become ill, which have improved as the wives recovered.

A long-term followup of the cases treated in our unit, over at least a generation, is proposed. It does seem from the initial results that this type of unit not only provides therapeutic advantage to the patient, but to the family and community as well.

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[1] Cowie, Valerie: The incidence of neurosis in the children of psychotics. *Acta Psychiatrica Scandinavica*, vol. 37, no. 1, 1961.

Guides and Reports

CHILDREN AND THE THREAT OF NUCLEAR WAR. Sibylle Escalona. Child Study Association of America, 9 East 89th Street, New York 28. 1962. 28 pp. 40 cents, with quantity rates available.

Reports some observations on the psychological impact of the nuclear threat on children, suggesting ways that parents and educators can deal with children's questions about the subject.

THE CHURCH NURSERY; a guide for health and safety. Maternal and Child Health Division, Michigan Department of Health, Lansing. 1962. 7 pp. Single copies free on request from the Michigan Department of Health.

Suggested standards for facilities and operation of nurseries established by churches to care for children under 2 while their parents attend services.

RECENT ADVANCES IN DEGENERATIVE DISEASES OF THE CENTRAL NERVOUS SYSTEM IN INFANTS AND CHILDREN: report of the 42d Ross Conference on Pediatric Research. G. M. Owen, editor. Ross Laboratories, Columbus 16, Ohio. 1963. 104 pp. Limited quantity free on request from Ross Laboratories.

Fifteen scientific papers presented at a conference held in April 1962 under the auspices of the University of Oklahoma Medical Center.

DAY CAMPING FOR THE MENTALLY RETARDED. David Ginglend and Kay Gould. National Association for Retarded Children, 386 Park Avenue South, New York 16. 1962. 55 pp. 25 cents.

A guide outlining the value of day camps for retarded children; elements to be considered in organizing these camps, selecting staff, and planning activities; the use of camping as a training period; and ways in which the camp and home can work together.

DIAGNOSING FAMILY FUNCTIONING

NATHAN W. ACKERMAN, M.D.
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A FEW MONTHS ago a volume was published which offers a framework for a social casework approach to multiproblem families, based upon a specific research project. To judge the value of this work, "Family Casework Diagnosis," by Alice L. Voiland and Associates,* is no light task. Inevitably, a judgment of this sort is influenced by what one sees in the book, who sees it, and the position from which one does the seeing. This is controversial material on a highly controversial subject. Moreover, the present review must contain an element of special bias, since it is written by a psychiatrist and is influenced by his special interest in the psychodynamics and psychotherapy of the family group.

The aim of the study which this book reports was to find ways to improve diagnosis of the phenomenon of family disorder by designing a system of classification which would enable social caseworkers to deal more effectively with families burdened by dependency, ill-health, and maladjustment. It was one phase of an ongoing series of studies conducted under the auspices of Community Research Associates and was influenced at the start especially by a pilot study in 1952 which resulted in a classification of disorganized families according to 10 types of marital axes.

The method of investigation used was the rigorous analysis of a sampling of case material involving 888 families viewed as representative of the caseload of 50 agencies which report annually to the Family Service Association of America. Two basic types of data are presented: the statistical analysis of the characteristics of the 888 families; and a special study of a group of 100 of these families combining statistical analysis and casework interpretation.

The families had been carried in casework treatment from 4 to 18 months or longer. Of the 888 families, 87 percent had had more than five interviews: 62.7 percent of these interviews had been with husband and wife; 33.6 percent with wife only; 3.6 percent with husband only. Thus, these figures reflect not so much treatment of whole families as treatment of selected members of these families.

Social functioning and dysfunctioning of the families were evaluated in three areas: (1) child rearing; (2) marital functioning; (3) financial functioning.

Psychosocial disorders were classified in two categories, Level A and Level B. Level A consists of behavior that is prohibited by society or represents a failure to perform obligatory social duties in accordance with specific laws or rules, or conditions that require legal or official intervention. This category is exemplified in financial irregularities, antisocial acts, commitment of a family member to a mental institution, and family dissolution such as separation or divorce. Level B consists of behavior representing failure in types of social responsibility that do not fall into the category of Level A, such as severe maladjustment of parental functions or of child development, and distorted concepts of marital relationships. Of the group of 100 families studied, 50 percent showed Level A psychosocial disorders, 43 percent showed Level B psychosocial disorders.

From the findings, the authors suggest a classification of four disordered family types. They are: (1) the perfectionistic family; (2) the inadequate family; (3) the egocentric family; (4) the unsocial family. Beginning with the first category, the perfectionistic family, the authors assume that there is a serial progression from the milder to the more malignant patterns of disorder, culminating in the fourth and worst category, the unsocial family.

The perfectionistic family is described as one which places undue emphasis on being without fault and on avoiding open friction. The members believe that they do not measure up to the standards set for them by others or to those that are self-imposed. In this type of family, the parents emotionally overtax themselves and the children.

The inadequate family is characterized by increasingly poor resistance to the ordinary stresses of family living. It relies too readily upon others for encouragement, continued support, guidance, and help in resolving problems which the average family would be able to resolve for itself.

The egocentric family is characterized by the self-seeking intentions of its individual members. Its predominating characteristics are the self-centeredness, the overbearing manner, and the opinionated attitudes of the marital partners, which exacerbate problems of child rearing. While these characteristics may be held in different degrees by the male and female partners, the "aggregate effect" of the narcissistic needs of both parents establishes the family's distinctive emotional tone.

The unsocial family—the family which lacks social rapport with other people and with the environment—is viewed by the authors as the most malignantly disordered type. Its emotional climate and characteristic behavior are conditioned by the following tendencies present in both partners, and usually in the children: (1) a paucity of ideals in the resolution of ordinary problems; (2) deviant social conduct that constitutes a major or minor offense against the culture; (3) thought processes and powers of concentration so twisted that the individual endangers his own welfare or another's or becomes the victim of designing persons. More than one member is personally and socially maladjusted to a serious degree, either socially or legally. This handicaps the marital relationship, the parent-child relationship, work habits, child development, and the family's relationship with the community.

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*Voiland, Alice L., and Associates: Family casework diagnosis. Columbia University Press, New York. 1962. 369 pp. $8.50.

The authors of this work believe that the study they report contributes three new elements to the field of family casework: (1) the classification of systems of psychosocial disorder; (2) the classification of disordered family types in clinical terms; (3) a framework for family diagnosis suitable for analysis of psychosocial data about families.

Clearly, this report is an earnest effort, an ambitious and comprehensive attempt to shed further light on the problems and manifestations of family disorganization. The validity of the sampling procedure can be assumed, since this was carefully checked by expert consultants. There are, however, a number of questions which might be raised concerning conceptualization, method of data collection, and also the final interpretive conclusions.

Some Questions

In regard to conceptualization, the authors are confronted with the same difficulties that beset other investigators who set out to study family process. These difficulties derive from the need to delineate the links between individual functioning and family functioning, and to identify the nature of the exchange between the two which influences each in turn. The theoretical framework was influenced by and yet departed from the 1952 formulation of the 10 marital-axis types. In the text, one finds some apparent efforts to resolve contradictory sets of evidence. To illustrate:

> In so far as methodology was concerned, it appeared that the use of the 10 marital axes as the main points of focus for the analysis of family data had not yielded significant results. . . . There did not . . . seem to be any correlation between the nature of the marital emotional tie and the presence or absence of typical psychosocial pathology in other areas of adult behavior, such as child rearing, earning a living, or in the adjustment of children. . . . In other words, the fact that two spouses got along well together did not make the family invulnerable to other types of problems. . . . *There was clinical evidence, but inconclusive statistical evidence* (italics mine) that the character of the relationship between the two partners somehow related to the functional capacity of the total family.

The real issue is—how related?

The pilot study team of 1952 believed "that the soundest way, initially, to approach the problem of family classification was to proceed from the biological foundations of the family as represented in the male-female relationship of the marriage."

The classification of four disordered family types used in this study has, according to the authors, a "somewhat different base:" It derives from the aims of the marital partners as expressed in the marital relationship, child rearing, child development, and the financial functions of the family. What does the phrase, "somewhat different," actually mean? If the psychosocial functioning of the group can only be evaluated in relation to the family as a total living unit embracing all family functional areas, as the authors say their clinical evidence implies, then there seems to be a discrepancy between the type of information sought and the procedure used to obtain it.

This brings us logically to the second question, the method of data gathering. This procedure, based on interviews with individual members of the family rather than on direct observation of the whole family in action, does not seem congruent with the aims of the study—the achieving of a dynamic definition of the family unit.

The family is more than the sum of its parts. The attempt to arrive at a picture of the whole family by looking at separate individuals or only at the marital pair leads to an incomplete and inaccurate synthesis. A more suitable and more accurate method for obtaining and integrating observations relevant to a live picture of the functional family unit is the exploratory, therapeutically-oriented interview with the living family group—parents, children, and where indicated, grandparents or other significant relatives.

What Comes First?

The investigators were faced with a painful dilemma. At some levels there were contradictions between the clinical findings and the evidence presented by supposedly objective statistical analysis. Which should they rely upon?

At the present stage of development in the behavioral sciences, our knowledge is relatively crude. At the borders of tested knowledge investigators not infrequently are tossed into sharp conflict. If two methods of investigation present contradictory evidence, on which method shall they pin their faith?

Alice L. Voiland will respond to some of Dr. Ackerman's comments about the study described in her book, "Family Casework Diagnosis," in the July–August 1963 issue of CHILDREN.

In the special area of the relations of family dynamics to social health and mental health, it seems to me the first responsibility is to seek out the core concepts, to implement the clinical hunch in the design of an appropriate and valid conceptual framework. Until we achieve this, it will be difficult to know what to measure and how to measure. Statistical analysis, applied in advance of accurate and adequate conceptualization of the relevant dynamic phenomena, may bring only confusion.

However, when we look at the 13 main sections of the 42-page schedule for obtaining information for this study, we find a conceptual movement from parts of the family, either individual members or the marital pair, to the family as a dynamic unity. To obtain what is sought, is it not important to begin rather with the family as a dynamic functional unity?

Only in this way can one design a satisfactory theory of family dynamics and development which incorporates an appropriate theory of role adaptation and also a theory of personality. The design of such a conceptual framework would be facilitated by a procedure involving exploratory interviewing with the family as a functional whole. The idiosyncratic pattern of equilibrium of the multiple functions of the family group is the central property of the family phenomenon that should be illuminated in any theory of family behavior, both in illness and in health.

The troublesome questions the authors of this study faced in interpreting their data are of course the results of earlier problems in conceptualization and method of study. In the description of the four disordered family types, they refer again and again to the "aggregate effect." In other words, these four diagnostic family types derive somewhat from the adding up of the character traits of the family members, especially the character traits of the two parents. This is not quite the same as a definitive characterization of the family as a functional unity reflecting in a unique way the homeostatic processes of the family group. One would be inclined to suspect that these characterizations of family types refer to component qualities of family functioning rather than providing a dynamic definition of the family entity as a living whole.

One might also raise the question as to whether these four types of families exist phenomenologically on the same level or on different levels. Compare, for example, the perfectionistic family and the unsocial family.

It is relevant, also, to consider to what extent the types of family functioning described are culturally bound. Are the adaptive patterns themselves the reflection of certain kinds of cultural and class belongingness? From the description offered of the perfectionistic family type, it would appear so; but the unsocial family type seems to relate to a conspicuous form of sociopathic family adaptation that takes the family out of the surrounding community cultnre.

In dealing critically with this study one must also consider the implications of its seemingly one-sided focus on the so-called multiproblem family. It is as if such families are the disorganized and sick ones while the other families in the community function in at least a tolerably satisfactory manner. But this of course is not true. The multiproblem family may represent the extremes of dysfunction, but the seeds of disorder in contemporary community life invade all types of families. This may be obvious, but it ought not to be either overlooked or minimized.

The study makes reference to an idealized normal family, but the model of such a family is not presented. There is a need for the development of a total theory of family dynamics out of which we may derive levels and degrees of deviance which would encompass multiproblem families, as well as families of other types.

The explicit consideration of these debatable questions is essential. The emergence in this study of some contradictions of evidence and the resulting complexities of interpretation simply affirm the sheer scientific enormity of the problem of family dynamics. This in no way detracts from the merit of this contribution to theories of social casework. Without doubt it will be widely read and discussed.

The author wrote this essay review after consultation with Frances Beatman, Sanford Sherman, and Celia Mitchell of the Jewish Family Service, New York.

BOOK NOTES

LESSONS FROM ANIMAL BEHAVIOR FOR THE CLINICIAN. S. A. Barnett, editor. Medical Advisory Committee of the National Spastics Society, 12 Park Crescent, London, W. 1, England. 1962. 51 pp. $2 or 12 shillings and sixpence.

This collection of six essays, by zoologists and behavioral scientists, focuses on the implications of research in animal behavior for an understanding of human development.

In the opening essay, S. A. Barnett of the University of Glasgow pinpoints areas that such animal research can enrich: human learning processes, the physiology of anxiety, and the distinction between stereotyped behavior common to a species and innate drives.

Some of the research findings stressed in the following essays are: that there is an optimal level of stimulation for each individual, and, up to a point, stimulation in early life produces a superior animal, who learns faster, is less emotional and more highly motivated and more resistant to stress, but stimulation beyond that point produces the opposite results; some stressful stimulation is needed in infancy if the endocrine response to noxious conditions is to develop best; and there is an optimal stage in each animal's life for development of each sort of behavior and the learning of each skill and inhibition.

WORK-STUDY PROGRAMS FOR ALIENATED YOUTH: a casebook. George W. Burchill. Science Research Associates, Chicago, Ill. 1962. 265 pp. $4.95.

Dave, the school dropout with a background of repeated failures, who graduated from a work-study program to a full-time job, and Fred, truant and gang leader at 16, who, during a work-study program, became convinced by his part-time employer to stay in school and try for a diploma, are among the 25 youths whose histories this book cites in a sampling of what is being done for young people in 9 work-study education programs.

The book describes programs conducted by eight public schools and one quasi-public institution for delinquent boys, all selected as outstanding by the Commission on the Role of the School in the Prevention of Juvenile Delinquency of the educational fraternity, Phi Delta Kappa.

A LETTER TO JIMMY. Henry Viscardi, Jr. Paul S. Eriksson, Inc., New York. 1962. 165 pp. $3.50.

"The trick is to reach out and be a part of the world now," explains this book-length letter to a disabled youth, a blend of peptalk and a briefing on how to carve out a full and rich life for himself. This is done, says the author—who, though born without legs, founded and now heads a firm hiring over 400 disabled—mainly by making one's abilities, not disabilities, count.

Writing for disabled youth everywhere, the author discusses questions of career, school, marriage, and sports, frequently illustrated by real life situations encountered by disabled young people he has known.

HERE AND THERE

Day Care for Children

A review of day-care activities within the States indicates that the State welfare departments have been getting ready to take advantage of earmarked funds for day-care services should these be made available by Congress as authorized in the 1962 amendments to the Social Security Act. Among the requirements for qualifying for such funds after fiscal 1963 are:

- *The existence of a State advisory committee on day care.* In 31 States, statewide advisory committees on day care either have been established or are in the process of being established. Activities of these committees vary according to the level of development of day-care services in the State. Improvement of standards of day care appears to be the task most of the committees tackle first, a survey of needs in the State comes second. The committee will also advise the States on such problems as employment of staff, setting fee scales for parents to pay according to ability, and planning for training personnel.

For example, in Maryland the day-care commission plans to assess available facilities for children and their adequacy in quality, quantity, and distribution; to improve standards; to review the licensing accreditation system; to make recommendations on the establishment and coordination of services, the sources from which funds may be obtained, the appropriate State agency to be given responsibility for carrying out the day-care services program, and needed legislation. The commission has been holding public hearings in various parts of the State to determine what communities are doing and what needs to be done; has arranged with the State's departments of health, education, and welfare to send a questionnaire to their respective local affiliates to assess day-care activities; has employed a research specialist to develop a prospectus for action after all the information is gathered and coordinated; and has planned for a State conference on day care to be held in Baltimore on October 31.

- *Provisions for licensing day-care facilities.* Two States, Massachusetts and Wyoming, passed licensing laws within the past year and similar measures are pending in a number of other States. Altogether 51 States and other jurisdictions either have licensing authority for day care or have licensing bills pending in their State legislatures.
- *Cooperative arrangements among the State welfare, health, and education departments.* In 36 States the health, education, and welfare departments work together on some aspects of day care, most often through representation on committees to develop or improve standards. In a few States the three departments give consultation to each other. In several States the health department provides inspection in facilities licensed by the welfare department. In at least one State there is a written cooperative arrangement.
- *The employment of day-care staff by the State welfare department.* Fourteen States now have such staff.

Most of the 36 States which now include provision for day-care services in their child welfare services plans, using Federal child welfare services grant-in-aid funds for the purpose, have indicated that if earmarked funds for day care become available, they will expand these provisions. The plans for expansion include establishment of family day-care programs; the opening of day-care centers under public auspices; the purchase of care for children in established licensed facilities; the development of intensive training courses for day-care personnel; the provision of day-care services to children of agricultural migrants; and the employment of licensing and consultation staff.

Problems which seem to be faced in many States are: (1) lack of trained personnel equipped to carry day-care responsibility; (2) pressure to utilize day care to get families off the public assistance rolls without consideration of the best plan for the child and the family; (3) lack of adequate facilities in which to place children; (4) lack of services for infants and school-age children.

Increased interest in developing research and demonstration projects in the field of day-care services is evident from the many requests received by the Children's Bureau for research and demonstration funds. Among the recent grants which have been made is one to the University of Illinois School of Social Work for training nonprofessional persons for licensing independent family day-care homes and independent foster homes.

—GERTRUDE HOFFMAN

Research and Demonstration

By early April of this year, 11 international research projects in maternal and child health and social welfare, to be supported by U.S. counterpart funds, had been approved. The projects are to be undertaken in Israel, Pakistan, and India.

Sponsored by the Welfare Administration and the Children's Bureau, U.S. Department of Health, Education, and Welfare, the projects were made possible by provisions of the Agricultural Trade Development and Assistance Act of 1954, as amended. Under this act foreign currencies accepted by the United States for the payment of surplus agricultural commodities can be used for studies of value to the United States and to the country conducting the research. Appropriations of such funds to the Welfare Administration made by Congress for 1962 for cooperative research in social welfare and maternal and child health make possible the development of research projects in these fields in Poland, the United Arab Republic, Yugoslavia, and Burma, as well as in the three countries with ongoing projects.

Projects underway in Israel include a longitudinal study of growth and development of children from various social strata and ethnic groups in that country, and studies of the socioethnological factors in the etiology of toxemia in pregnancy, the institutionalization of children, the forces acting in street-corner groups, and social services from the user's viewpoint.

Two projects are underway in Pakistan—a survey of diarrheal diseases among children in that country, and a study of the effectiveness of social work training at Punjab University in relation to the social welfare needs of Pakistan. In India a study of the role of a community development program will appraise factors influencing the acceptance and rejection of innovations by the villagers.

India and Israel have submitted a number of additional projects for review. Projects are also being planned in the United Arab Republic, Poland, and Yugoslavia.

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Ways to improve the lot of children whose mothers are hospitalized for mental illness are being sought in a demonstration project of the Department of Maternal and Child Health of the Harvard School of Public Health, preliminary findings of which were released last fall. Centered in one of Massachusetts' State mental hospitals, at Medfield, which serves patients from 15 communities, the study is designed specifically to improve casefinding of children needing help when the parent is admitted or about to be admitted to the hospital; to develop ways of assessing family needs, strengths, and resources for remaining intact, and methods of assessing the need to strengthen community agencies' help to them; and to evaluate the effectiveness of the relationships between the families and community agencies. Other goals are to determine whether community services can be organized to provide supportive and comprehensive care for children of families with repeated hospitalizations; and to analyze family difficulties in the care of such children and family experiences during crises of mental illness and hospitalization.

The project is in followup of a 1958–60 pilot study of children of parents hospitalized for mental illness to determine what arrangements had been made for their care. (See CHILDREN, May–June 1959, p. 114.) The current project is underway in three communities: Newton, Quincy, and Needham, with community leadership in the project assigned to a single agency in each community.

At the hospital, a project staff member assesses the family situation of selected patients with children, visits the child's caretaker at the family home, and refers the family to the community agency for service if needed. A control group will be studied without referral for service.

A preliminary analysis reported on at the annual meeting of the American Public Health Association last fall revealed that the project has brought about fuller history taking on admission to the hospital, which formerly had asked for little or no information on the patients' children; and has led to the assumption by the hospital social worker of the liaison function with community agencies and to her participation in community planning for the patients and their families. The investigators point to the need for overcoming families' resistance to community help and the need for agencies to modify their relatively greater emphasis on long-term casework directed to the more chronic disorders of spouse or children rather than on services directed to the acute problem.

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The National Institute of Child Health and Human Development, authorized by Congress in 1962 (CHILDREN, November–December 1962, p. 242), was established by the Public Health Service on February 4 of this year. The new Institute's functions—research into the health status, needs, and problems of human beings in various stages of development—are organized around two research centers formerly in the Division of General Medical Sciences of the National Institutes of Health: the Center for Research in Child Health, and the Center for Aging Research. Director of the Institute is Dr. Robert A. Aldrich, formerly chairman of the pediatrics department of the University of Washington School of Medicine.

Dependent Children

The great majority of jobless fathers on the rolls of the Federal-State program of aid to families with dependent children are school dropouts, many of whom are equipped only for unskilled labor, according to preliminary findings of a survey of recipients, conducted by the Bureau of Family Services, Welfare Administration, and released in February of this year. At the time of the study, in late 1961, only 9 percent were found to have finished high school, compared with the 40 percent of men in this country who are high school graduates. Only 3 percent had been white collar workers, as against almost 35 percent in this category among the Nation's employed males. About 3 percent had never held a full-time job.

No father was present in almost 78 percent of the AFDC homes. The father was present but incapacitated in about 15 percent of the cases, and was at home but unemployed in 5 percent. In 2 percent of the cases, the need for assistance was caused by the mother's absence, disability, or unemployment.

The median age of the unemployed fathers in the AFDC program was 34.7 years, almost 4 years below the median for all heads of husband-wife families with children under 18 in the Nation. Nearly one-third of them were under 30; only 20 percent were 45 or older.

Child Welfare

The Field Foundation recently granted $55,000 to the Child Welfare League of America for a 3-year project to promote the use of uniform cost accounting procedures among institutions caring for children in the Nation. The project is being administered jointly by the League and the Children's Bureau, which together mapped out its design. This focuses on encouraging the use of the "Manual for Cost Analysis in Institutions for Children" published in the summer of 1962 by the League.

A coordinator, employed by the project, will promote the training of research, statistical, or accounting personnel on the staffs of State departments of public welfare, united community funds, federations of social agencies, and other organizations in the cost accounting procedures prescribed by the manual. These persons will in turn train and supervise staffs of local public and voluntary institutions in the procedures.

The manual was developed by the League and the California State Department of Social Welfare with the use of Federal child welfare services funds in response to a need, made especially apparent in purchase of care arrangements between public agencies and voluntary institutions, for more standardized procedures in determining costs of institutional care.

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A new voluntary agency, the National Council on Homemaker Services, was incorporated in January 1963, thus bringing to fruition a recommendation of the 1959 National Conference on Homemaker Services for the creation of a continuing national mechanism for studying homemaker programs and helping communities to develop them. (See "A New Look in Homemaker Services," by Maud Morlock, CHILDREN, May–June 1959, p. 112.) In February, the National Committee on Homemaker Service, which had a major role in the promotion of the new agency, voted to disband and to transfer its assets to the Council. Other organizations active in the creation of the Council were the National Social Welfare Assembly and the National Health Council.

The new agency's board, composed of community leaders from various parts of the country under the chairmanship of Mrs. Juan Trippe of New York City, has set its first task as the raising of funds for agency operations, including the employment of staff. The Council's headquarters are in New York City.

Services in Housing

The Elm Haven Housing Project in New Haven, Conn., was selected early this year as the site of a demonstration project of concerted services for families in low-rent housing. (See CHILDREN, November–December 1962, p. 242.) This is the second project spearheaded by the Task Force on Health, Education, and Welfare Services and Housing in a coordinated effort of the U.S. Department of Health, Education, and Welfare, the Housing and Home Finance Agency, and State and local agencies to lift the health, social, and economic status of residents in public housing developments.

The characteristics and needs of families in the 855-unit housing project in New Haven are under study by a committee of Community Progress, Inc., on which are representatives of State and local agencies concerned with the project's services. Subcommittees have been set up to focus on education and employment; health; school readiness; family welfare; residents' participation; and youth and recreation.

A grant of $82,529 per year for 5 years was recently awarded by the Federal Vocational Rehabilitation Administration to the Missouri State Department of Vocational Rehabilitation to set up a special vocational rehabilitation unit in the Pruitt-Igoe Housing Development of St. Louis, site of the first concerted services project launched last summer. The new unit will provide rehabilitative services for mentally and physically disabled residents. These services are expected to include medical help, hospitalization, artificial limbs, and psychological and psychiatric care.

Staff Development

Financed by a grant of $104,925 from the Field Foundation, an institute to train staff development people in social work in State and local public welfare agencies was launched during early February in Washington, D.C., by the American Public Welfare Association and the Council on Social Work Education of New York with the cooperation of the Children's Bureau and the Bureau of Family Services, U.S. Department of Health, Education, and Welfare. Alice Taylor Davis of the Howard University School of Social Work is project director. About 100 participants, more than half of all those employed in full-time training of public welfare staff, attended the 2-week session, after which they returned for 3 months' practice on the job before reconvening for the final week of followup study.

The institute is designed to demonstrate an orderly method for organizing and presenting content in this area and help develop teaching skills and methods. Its purpose is to help State public welfare directors meet a regulation of the Department of Health, Education, and Welfare requiring that they have in operation by 1967 an effective, organized staff development program. (See CHILDREN, January–February 1962, p. 36.)

Manpower studies have shown that only 5 percent of public assistance staff and 25 percent of public child welfare staff are professionally trained. (See CHILDREN, July–August 1961, p. 154.)

Vaccines and Drugs

Licenses for the commercial output of two types of measles vaccines were issued March 21, by the Department of Health, Education, and Welfare, on the recommendation of the Public Health Service. Nearly 50,000 children in the United States received these vaccines in field trials, about 25,000 having been given the live vaccine, either alone or in combination with gamma globulin. (See CHILDREN, January–February 1962, p. 34.)

Simultaneously with the licensing action, the Ad Hoc Advisory Committee on Measles Control of the Public Health Service issued a statement to guide the Nation's physicians on the status of the measles vaccines and on their application. The statement indicates, among other things, that:

- The live vaccine induces active immunity after a single dose and produces, in the majority of those taking it, a mild or inapparent noncommunicable infection with minimal symptoms, but 30 to 40 percent have fever of 103° (rectal) or more. Strength and duration of antibody response resemble that of the natural disease. Standard Measles Immune Globulin given at the same time in the recommended manner sharply reduces clinical reactions.
- Antibody titers after three monthly doses of the inactivated vaccine are lower than those following the live vaccine and rapidly fall off. Duration of immunity beyond 6 months is unknown. This vaccine is preferred where the live vaccine is contraindicated: in the case of pregnancy, general malignancy, or egg sensitivity (since the vaccine is cultured in chick embryos).
- Live attenuated vaccine given 1 to 3 months after one or two doses of inactivated measles virus vaccine substantially lowers clinical reactions; the combination schedule of live and inactivated vaccines produces antibody titers higher than with the latter alone and apparently equal to those following live vaccine with gamma globulin.
- The vaccines are primarily for administration to children, ideally at 9 months or as soon thereafter as possible, and only for those without a history of measles. No protection is afforded by either vaccine after exposure to the natural disease.

* * *

In a resolution adopted early this year, the executive board of the World Health Organization has asked the director general of WHO to facilitate ways of compiling information on serious adverse drug reactions and supplying this information to national health agencies. In the same resolution the board recommended that the World Health Assembly, convening this May, invite member States to seek agreement among members on the basic principles and minimum requirements applicable to the evaluation of drugs and to make available to WHO for rapid dissemination any action taken to prohibit use of a drug because of adverse reactions.

IN THE JOURNALS

Neglect and Abuse

The March 1963 issue of *Child Welfare* is focused almost entirely on the subject of neglect or abuse of children.

In one article six staff members of the Massachusetts Society for the Prevention of Cruelty to Children report on a study of abuse cases which found that the great majority of child abusers were the parents of the children, and that they tended to be young and to fall into three clusters of personality characteristics—hostile and aggressive; rigid, compulsive, and lacking in warmth; and passive and dependent. ("Physical Abuse of Children—An Agency Study.")

In other articles, a hospital social worker outlines problems of identifying neglecting parents and those among them who are likely to respond to treatment ("Who Insures the Child's Right to Health?" by Helen E. Boardman); and a casework supervisor in a public child welfare agency writes of the importance of an agency's experience and philosophy in helping the protective service caseworker deal with pressures emanating from his own conflicts, the community, and law-enforcement bodies. ("The Protective Service Caseworker: How Does He Survive Job Pressures?" by Dolores M. Schmidt.)

Other articles consider child neglect from a legal viewpoint, the team approach in protective service, aspects of the Child Welfare League of America's standards for child protective service, and ways of prevention.

Becoming an Individual

Extracting from clinical observations made in a study of the separation-individuation phase of development in normal children (age range: 6 to 10 months to 3 years), two psychiatrists writing in *The Psychoanalytic Quarterly* for January 1963 report that the mother may read the infant's cues correctly, misread them, or selectively neglect cues, according to her particular needs, and that the normal child has "an amazing capacity to adapt to the needs, emotions, and demands of the mother." ("Certain Aspects of the Separation-Individuation Phase," by Margaret S. Mahler, M.D., and Manuel Furer, M.D.)

Their material, gathered from observations of mother-child interaction in a large playroom and from interviews with the mothers, demonstrates, according to the authors, a large range of response in normal mothers to separation from their children—reactions ranging from near mourning, attempts to hurry independent functioning, subtle combinations of both, and "seesawing" between psychologically getting rid of the infant and clinging to him. Noting that the normal mother anticipates separation-individuation in her baby long before he is actually at this phase, the investigators conclude that the child's pattern of individuation stems in large part from the mother's attempts to adapt to the child's maturation and his own efforts to adapt to his mother's fantasies.

Growing Up Negro

Under the title "Growing Up Negro," the January issue of the bimonthly journal *American Child* is a special issue on the problems of Negro youth. Its four articles, each written by an executive of a youth-serving agency, analyze the adverse effects of present-day racial discrimination in employment, housing, and education on Negro youth, American society, and the Nation's economy, and the shortcomings of steps being taken to overcome the resulting problems; and make specific suggestions for achieving more rapid progress.

Foster Family Sessions

The value of adapting family session techniques to the supervision of children in foster family homes, by interviewing the child and the foster parents together, is discussed by two social caseworkers in *Social Casework* for March 1963. ("The Use of Family Sessions in Foster Home Care," by Dwaine R. Lindberg and Anne W. Wosmek.)

Maintaining that the traditional approach of seeing the foster mother alone unwittingly separates her from the family, they point out that family interviewing gives the caseworker an opportunity to observe directly the interaction between the foster family members and the foster child and minimizes the concern of foster parent and foster child over the caseworker's reactions to what has been reported about them by the other. They also assert that the family technique promotes broader understanding by the clients of the caseworker's role, and enhances communication between foster family and the child in relation to the conflict created by the child's divided loyalties between his own and his foster parents.

Handicapped Children

Some of the services that bring greater usefulness and independence to the Nation's 4 million handicapped children are discussed in a special section of 5 articles in the March–April issue of the *Rehabilitation Record*. ("Special Services for Handicapped Children.") The section provides a general look at the extent and type of both mental and physical disability among young people and discusses existing and prospective special education programs to meet their needs. Two programs that give special training to handicapped young people are described—one in the public schools of Champaign, Ill. ("A Bridge from High School to Work," by E. C. Cline and Merle B. Karnes), and the other in a residential school for handicapped children in Jamestown, N. Dak. ("The Case for the Residential School," by Anne H. Carlsen).

Human Dignity

In the January 1963 issue of the quarterly *Public Welfare*, Marvin E. Larson, director of the Kansas State Department of Social Welfare, writes of human dignity as "the most important single achievement of the human race" and "the basis of all morality." He warns of the danger of intrusions upon this concept when the "aristocracy of the capable" fails to understand the inequalities of birth, nurture, and opportunity behind the failure of some persons to achieve a strong sense of responsibility. ("The Aristocracy of the Capable.")

In the same issue, Dorothy J. Kiester, consultant on community services to the North Carolina State Board of Public Welfare, stresses the importance of *caring* in efforts of public welfare workers to mobilize community resources to meet the needs of children. She names as essential to such efforts the ability to see the individuals in a caseload, knowledge of the resources and ability to work with the people who control them, a willingness to share, and investment in training. ("Mobilizing Community Resources to Meet the Needs of Children.")

Impaired Speech

In *School Life* for March 1963, Nancy E. Wood of the Office of Education reviews the speech impairments most frequently encountered in the classroom—in phonation, fluency, articulation, and language—supplying clues for identification by the teacher. ("Identifying Speech Disorders in the Classroom.") Noting that most of the disorders are associated with voice strain or misuse, she advises teachers to refer the child with a deviant voice quality for laryngeal examination before scheduling him for help in school and to provide group therapy or other indirect treatment for the child with defective articulation.

MOVING AHEAD AGAINST MENTAL RETARDATION

HOW TO MOVE ahead to carry out the recommendations of the President's Panel on Mental Retardation was the subject of an all-day conference held in Arlington, Va., on April 9, as the swan song of the Citizens' Committee for the 50th Anniversary of the Children's Bureau, which sponsored the Bureau's stock-taking birthday party on the same date a year ago. (See CHILDREN, May–June 1962, page 120.)

The 75 conferees included members of the Citizens' Committee, representatives of the President's Panel on Mental Retardation and its Task Forces and of the Children's Bureau staff, and specialists from the fields of pediatrics, obstetrics, and other fields concerned with the mentally retarded. Their point of departure was the panel's report, "A Proposed Program for National Action to Combat Mental Retardation," which was submitted to the President last October (see CHILDREN, January–February 1962, page 29). Featured speakers at the general sessions included: Secretary of Health, Education, and Welfare, Anthony J. Celebrezze; Leonard W. Mayo, chairman of the President's Panel; Mrs. Sargent Shriver, consultant to the panel; Edward Davens, deputy commissioner of health for the State of Maryland; Donald Stedman, associate director of research for the Joseph P. Kennedy, Jr., Foundation; and Gunnar Dybwad, executive director of the National Association for Retarded Children.

A considerable part of the speeches as well as of the deliberations in afternoon group discussions was devoted to the possibilities of pending congressional legislation for stimulating State and local action, both of a public and voluntary nature, to prevent retardation as well as to provide better services to the retarded. Prevention, it was generally agreed, necessarily involves activities beneficial to the entire population, such as research into fetal and neurological development to identify the points where damage occurs, efforts to improve and extend prenatal and postnatal care, and the provision of nursery schools and kindergartens to provide intellectual stimulation to children early in life.

Consideration of where to start in the development of a comprehensive program of prevention led to an apparent consensus that this must be with "high risk groups"—the women of low socioeconomic status who are not getting adequate prenatal care and the "culturally deprived" children of the same socioeconomic background. One conferee, however, remarked that in the slum cores of some large cities such "high risk groups" would consist of all the women and children in the area.

The conferees put considerable stress on educational efforts—to help the unmotivated, high risk groups appreciate the importance of preventive services, to help the retarded themselves to develop their capacities, and to help physicians, social workers, teachers, and the general public achieve a better understanding of the needs of the retarded and their families. Stress was also put on the importance of expanding professional education to help meet the manpower needs of an expanded program, and of training volunteers and middle-level auxiliary personnel to supplement the efforts of the highly skilled in the provision of services.

Concern about how to reach the "unmotivated" with appropriate services—especially prenatal care—focused largely on the way services are provided and the attitudes of the servers, with emphasis on the need for greater consideration of the dignity of the client as a human being. The enhancement of human dignity was, in fact, identified as the chief reason for providing special and basic services to the mentally retarded and for the President's proposals to Congress on February 5 this year that Federal funds be provided for the establishment of 10 research centers concerned with mental retardation and grants to the States for the construction of facilities for the retarded and for the development of comprehensive plans of action in relation to mental retardation.

"While all people are not born equal," said Melvin A. Glasser, chairman of the Citizens' Committee, "the very definition of democracy demands that they have equal access to opportunities for development."

—KATHRYN CLOSE

READERS' EXCHANGE

BERNSTEIN: *A stimulus to reappraisal*

Rose Bernstein, in her article, "Gaps in Services to Unmarried Mothers" (CHILDREN, March–April 1963), has given us some words which should make us do some critical thinking about unmarried mothers, about ourselves as members of the helping professions, and about our services and their utilization as well as the lack of services.

It is not enough to provide services to unmarried expectant mothers and then wait for them to take the initiative in seeking help. We must develop and use sound techniques to encourage persons in need to use these services. In some instances, we may have to take the first step not only toward the unmarried expectant mother but also toward the unmarried father and the families of both if we really want to do anything about gaps in services.

It is easy to think only of the gaps in other community services without facing the gaps within one's own agency. Many of us have built into our agency programs mechanisms for continuing review of policy and practice. Let's take another look. For example, take several statements in the Bernstein article relating to maternity homes:

- That many maternity homes tend to give priority to mothers who plan to relinquish their babies.
- That some maternity homes frankly or indirectly discriminate against Negroes in their admission policies.
- That maternity homes, which serve only 10 percent of the unmarried mother population, are taking on the character of small psychiatric centers, thus raising the question of whether a proliferation of services for a small segment of a client population is the most effective allocation of community resources.
- That attempts to keep unmarried mothers in followup treatment are not significantly successful.

This may be the time to rethink the purpose and goals of the maternity home as community agency not only in relation to these statements, but also in relation to changing times. For example, is there any justification for offering service on the basis of whether plans are to keep or relinquish the baby? I have heard some social workers say that we may have to encourage the unmarried expectant mother to keep her child because of the reported decline in available adoptive homes. What is the rationale for helping the unmarried mother to surrender her child in a time when there is an oversupply of adoptive homes and helping her to keep the child when we anticipate a shortage of adoptive homes?

In addition to our responsibility for agency self-examination, we have a responsibility in relation to gaps in other community services. Mrs. Bernstein refers to the 1962 amendments to the Social Security Act as a forward step in developing services to unmarried mothers. We have a responsibility to contribute to State implementation of these amendments. The National Social Welfare Assembly, 345 East 46th Street, New York, has developed a checklist of questions on State public welfare legislation. You can get it for 15 cents if you want to do something about closing the gaps in service.

Jane E. Wrieden
Colonel, The Salvation Army

PANNOR: *Unmarried fathers*

At the recent annual meeting of the American Orthopsychiatric Association in Washington, D.C., many people stopped at the booth of the National Association on Service to Unmarried Parents to express approval of the title of the organization—"Unmarried Parents," instead of "Unmarried Mothers." I am pleased to see that the Children's Bureau also carries out this idea in the March–April issue of CHILDREN, with the overall title "Unmarried Parents." I would like to comment on one of its articles, "Casework Services for Unmarried Fathers." The author, Reuben Pannor, and his agency deserve our highest praise for what they are doing. Over a period of years they have given consistent service to the boys and men, fathers of the children born out of wedlock, for whom the agency has assumed some responsibility.

The "Child Welfare League of America Standards for Services to Unmarried Parents" also emphasizes the importance of work with the father as follows: "The unmarried father, especially the adolescent, should have an opportunity for casework help. Social agencies . . . should *reach out* to the father more than they have in the past. . . . Special efforts should be made to work with him, and to develop studies regarding him. . . . In providing casework help to the unmarried father, it is important to regard him as an individual with his own needs and problems, rather than as an adjunct to the plan for the unmarried mother and child, or only as a source of financial support."

The public at large, the legal and medical professions, social and health agencies, and our schools, in one way or another, are concerned with this trio of mother, father, and baby. But the attitude expressed toward the father may be vastly different from that toward the mother. Social agencies, by and large, have only slight knowledge of the father—usually what the girl chooses to tell them. Rarely, is there direct contact with him. Mr. Pannor suggests some of the reasons why. This boils down to the lack of conviction of the importance of the man in the total situation.

One hears much concern expressed, and rightly, over pregnancies in our schools, and the tragedies that often occur to both the boys and girls. Not a panacea, but one development that might help would be for a concerted effort to get more social workers in our schools. Hopefully they could see signs of danger and perhaps lend a hand before it is too late.

The problem of young unmarried parents is part of the wider problem we face—how to help young people grow strong enough to make wise choices and fulfill their potentials as responsible human beings.

Maud Morlock
Former Consultant on Services to Unmarried Parents, Children's Bureau

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Frontispiece, Esther Bubley for the Children's Bureau.

Page 107, Association for the Help of Retarded Children, New York City Chapter.

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SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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CHILD WELFARE STATISTICS, 1961. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Statistical Series No. 66. 1962. 84 pp. Single copies available from the Bureau without charge.

This compilation of data on child welfare programs during 1961 presents through 122 statistical tables information on: expenditures for public child welfare services; personnel in public child welfare agencies and those granted educational leave; children for whom adoption petitions were granted; and children receiving services of various types.

ORGANIZATION FOR CHILD WELFARE SERVICES; a statement on State-administered and State-supervised child welfare programs. Hannah M. Adams. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1962. 14 pp. Single copies available from the Bureau without charge.

Discusses criteria for determining the administrative responsibility for public child welfare programs which result in the following classification: local administration, 11 States; local administration, with regular exceptions, 9 States; mixed State and local administration, 3 States; State administration, with a few exceptions, 4 States; State administration, 26 States.

DESIGN FOR COMMUNITY ACTION; how to mobilize community resources to help youth enter the world of work. Department of Labor, Bureau of Labor Standards. Bulletin 248. 1962. 36 pp. 20 cents.

Part 1 discusses the employment problems of specific groups of young people—school dropouts, young people of minority groups, rural youth and those in agricultural migrant families, young people with physical and mental handicaps, and high school graduates with no vocational training—in relation to the changing requirements of the current job market.

Part 2, emphasizing community action, describes various youth service and training programs which have been organized by communities; suggests ideas to aid other concerned communities in planning, launching, and continuing a program to help young people achieve their work potential; and discusses the responsibility of Federal, State, and local agencies, national voluntary organizations, representatives of labor and management, educators, and others in promoting youth training and employment programs.

A PROPOSED PROGRAM FOR NATIONAL ACTION TO COMBAT MENTAL RETARDATION; a report to the President. October 1962. The President's Panel on Mental Retardation, Department of Health, Education, and Welfare. 1963. 201 pp. 65 cents (paper cover).

This report was reviewed in some detail in the January–February 1963 issue of CHILDREN. (pp. 29–31.)

YOUR BABY'S FIRST YEAR. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 400. 1962. 30 pp. 15 cents.

Designed for parents with low reading levels, this illustrated booklet explains the important points in baby care.

SELECTED FILMS ON CHILD LIFE. Inez C. Lohr. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 376 revised. 1962. 99 pp. 35 cents.

Superseding the 1959 edition, this catalog lists 400 films.

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◀

GOOD ENOUGH TO EAT? Sticky with the clay she has been playing with, this little girl licks her fingers, thereby following a tendency of many children to mouth their playthings. This may be more or less harmless—depending on the material in their toys—but if the child develops a persistent habit of actually eating nonedible materials, real trouble can ensue. The emotional and cultural factors associated with such a habit, medically known as pica, are described in the article beginning on page 143.

Nevertheless, the following observations derived from the inquiry may be useful to those planning programs to help culturally deprived parents improve the quality of their family life. Because of space limitations, the observations presented here are necessarily only a selected few of many that might be made. They apply primarily to groups of mothers, for while it was generally agreed that it is important also to reach the fathers in such families, this apparently is easier said than done.

Reaching the Educatees

According to most accounts, disadvantaged mothers, as well as fathers, are as a rule reluctant to come to a scheduled meeting. A typical reaction to an invitation to join a group is: "Who, me? Oh, no. I wouldn't know how to act." Few women in this social stratum have ever belonged to organized groups. Their remembrance of the group situation they encountered in their schooldays is often not a happy one. Some, new to urban life, are nearly as socially isolated in the city as they were in their rural homes, where their social contacts were few and, perhaps, rigidly controlled.

Thus it is apparent that to reach such families, parent educators must go at least 75 percent of the way.[2, 3] Various devices are used. Home visits to extend the invitation often bring good results when the visitor is sensitively aware of individual personality needs, cultural patterns, and the current situation of the families who are visited. Parents apparently want assurance that they, as individuals, will be genuinely welcomed into the program; that their everyday clothes are all right; that arrangements will be made for the care of their children (many agencies provide group programs for youngsters at the same time that the "mother's club" is meeting); that their friends and neighbors are also invited; and that the program will center on matters in which they are interested.

In some places other ways of reaching candidates for parent education groups have been found. One isolated, severely deprived community of Latin Americans in the Southwest was visited by a parent educator in an old truck, laden with bolts of brightly colored yard goods. As mothers gathered around she offered them several yards of fabric to create "something nice" for their homes, adding, "Wouldn't you like to come to the sewing class to find out how to make these things?" Many came. And as they sewed and talked, they learned much more than how to "sew a fine seam."

A group worker in a high-rise housing project in New York City used a similar method to bring mothers into the play-school program in which their children were enrolled. When the children were given an assortment of balloons, the bright colors and the children's shrieks of excitement lured the mothers from their apartments to the playground below. Once they were there, the leader found ways to involve them in the program.

In Syracuse, a family service center maintains a secondhand clothing exchange in a nearby housing project. Run by the mothers (with help from the agency's parent educator), this "swap-shop" permits mothers to obtain "credit-points" for clothing outgrown by members of their family; and to apply these credits to the purchase of clothing brought in by others. As the mothers carry on their trading (while the children are cared for in the adjoining nursery), a parent educator, trained in both home economics and social work, suggests that they might like to bring their new acquisitions to the center's sewing class so that the clothes can be "fixed up" to be a perfect fit. And again the "sewing class" turns out, under skillful leadership, to be far more than that.

Elsewhere, a group work agency has found that a party, to which parents are invited by personal telephone calls, is a good starting point for a parent education program.

A number of persons stressed the value of using local indigenous leadership. In one city neighborhood, for example, several mothers in the neighborhood who were generally well liked and respected were persuaded by the parent educator to form a small team to visit other parents to invite them to the meetings. In another, a university-based parent educator found that disadvantaged families attended an organizing meeting when their own neighbors provided the planning (with the professor's indirect guidance) and the entertainment, including a choir from a store-front church.

Several social agencies and school systems have launched "good housekeeping programs" at the request of public housing authorities which require some tenants whose housekeeping is objectionable to attend them on pain of eviction.[4] On page 134 of this journal, Esther Hill describes an experience of this nature in Philadelphia involving both group and individual approaches.

A well-attended meeting is, of course, only step 1 in an effective program. Our respondents described programs which seemed to "work"—at least in regard to maintaining the parents' interest—and those that did not. The latter tended to feature lectures by experts, panel discussions, or movies with a "middle-class bias," and often were only one-shot affairs. The one-meeting approach to parent education with deprived, uneducated families apparently does not produce much change in attitudes or living patterns.[5] Many parent educators say that programs with low-income families should, ideally, maintain a kind of open entrance and exit door for members, but should be available to them for at least 2 or 3 years.

Sewing Classes

"Doing" projects of an ongoing nature have seemed to generate considerable enthusiasm, fairly continuous attendance by more than half of the originally invited group, and evidences of changed behavior in at least some of the participants. Sewing classes seem to be especially successful, perhaps because they meet a number of important needs: the practical desire for clothes and household items, such as curtains, at low (or no) cost; and the psychological needs for engaging in creative activity and for achieving concrete, observable success. In order to meet such needs, sewing classes for disadvantaged mothers are usually conducted in a way that requires only a minimum of skill.

Some women who have suffered emotional deprivation in their childhood may also get some deeper emotional satisfaction from the warm "homey" character of these sewing classes. While any leader-group situation has overtones of the nuclear family scene, in sewing and other homemaking groups, the leader is especially apt to seem like a mother with a family of daughters. Moreover, along with the experience of being "mothered," the members of the group may have the chance to develop what some social workers would call "healthy female narcissism." For example, one of the authors witnessed the following in a Chicago housing project:

> Within the cozy sewing room, there was a relaxed atmosphere created by the mother-daughter relationship between the leader, a home economist and family life educator, and the mothers who were members of the sewing group. As she showed Mrs. Jones, a recent recruit, how to press seams in a newly made skirt, the leader teasingly commented that Mrs. Jones' husband would be glad to take her to a party now that she had something to wear. Mrs. Jones countered with "I'm going to look right sexy and that's a fact," but added that she hoped that this would not result in more "kids" as she had about all she could do caring for the two she had. At this the leader remarked, "You do a wonderful job with those little girls;" and Mrs. Jones beamed.
>
> The leader then turned to Mrs. Wilson, getting down on the floor to help her shorten a skirt. Mrs. Wilson, looking pleased, blurted out, "I just don't know what I would do without you. I'd *never* get my hems straight. You're the only one I can count on." The leader, too skilled to accept this much dependency, flashed back, "Your husband can help you. Take my skirt measurer home the next time you want to hang a skirt. Husbands *love* to feel that they are needed."
>
> Mrs. Wilson's doubtful look partly dissolved when Mrs. Barker chimed in, "I tried it out on my man, and he went around bragging that I wouldn't look half so good without his help."
>
> Mrs. Barker was enthusiastically engaged in making a hat, as were several other members of this sewing group, one of whom remarked, "There is nothing like a hat to make you feel like a lady."

Feeling like a lady is important to any woman. But mothers come to this sewing room for other reasons than this or even than making friends or being mothered. The sewing room is open every day and so offers them a resource in times of family crises. When a child is arrested for stealing, or a husband deserts, or a job is lost, a woman can grab up an old coat that needs fixing, head for the sewing room, and there ask for the kind of service she needs without seeming to ask. She can find comfort in friends and she can gain the understanding ear of the leader, who may provide the necessary counsel directly or lead her to the appropriate service.

Probably since the dawn of civilization, mothers have gathered in groups to perform some of their domestic tasks. And, as their hands have become busy, their tongues have become even busier. In such a setting, intimacies related to family concerns are exchanged behind the partial defense of doing something else at the same time. When intimacies become too painful, they can be dropped with the pretense that the dropped stitch or frying pan needs full attention. In sewing classes, led by a parent educator, such intimate conversations are skillfully and subtly guided to produce new insights, information, and perhaps changed attitudes in regard to family living and child care. The leader can help shift the flow of talk before self-revelation goes too far.

Other Approaches

Sewing classes, however, cannot be regarded as *the* superhighway to effective parent education with low-income families. They appear to be a good route for *some* educators and *some* parents. But not every woman—and almost *no* man—wants to sew. Moreover, some good parent educators are not sewers.

Pure discussion groups, generally brought together in the first place by means of some kind of "reaching out" technique, reportedly go well when members are active participants in planning the program as well as in the discussion itself. Discussions which focus on member-perceived day-to-day problems seem to be the most popular. Among the topics which have provoked enthusiastic participation have been: "keeping our kids out of trouble;" "what to do about bed wetting;" "what about our children and sex;" "raising children when there's no father at home;" "handling money."

When members of such groups are encouraged to tell what "works" for them, practical suggestions—some of them new to the parent educator—are often produced. However, parent educators find, as do caseworkers who work with disadvantaged families, that with these groups a firm, specific, approach is generally more effective than the abstract, permissive "line" often used with middle-class groups.

Usable parent education materials for groups of low education levels, such as films and publications, are, reportedly, all but nonexistent, most such materials being middle class in orientation and on too high a reading level. To help fill this gap, the Children's Bureau has recently prepared some booklets which are suitable for people who do not read easily, publishing them in Spanish as well as English.[6, 7]

Another approach to parent education with low-income groups is through the nursery or play-school in which the parents help professional teachers with planning and carrying out the children's activities,[8] thus having opportunities to learn new ways in child rearing. Some of our respondents believe that this method of parent education works well with low-income groups and some have strong doubts about its effectiveness. The doubters point out that many such parents are too overburdened with outer and inner stresses to give much of their physical and psychic strengths to this activity.

Some agencies sponsoring parents' discussion groups also add various kinds of "go-do" expeditions—to a supermarket, a department store, a park, or a museum. At first the leader accompanies the mothers to give them know-how and self-assurance, for many of the women have never ventured out of their immediate neighborhood. Later she withdraws from active participation but encourages them to make such forays in friendship groups and with their families. One agency calls this process "helping families move out of the cultural ghetto."

The importance of refreshments as part of the group meetings was frequently mentioned. These are kept simple and are usually planned by the group members themselves with help from the leader. Some leaders, however, gradually introduce low-cost homemade food items which members can learn how to cook themselves. [See p. 135.]

Refreshments are not only a treat for members but an aid in learning how to entertain in their own homes—important not only for themselves but also for their children. Food also provides a sense of belongingness and of festivity to mothers whose lives have been socially barren. For example, when one group served special refreshments in honor of a woman who had recently returned to the group after a long illness, she made a little speech of thanks to those who had visited her in the hospital and helped to take care of her children, ending: "It sure made it worthwhile to get well."

Of course, refreshments do not *build* this kind of group feeling. But they help as part of the total process through which clubs, on any level of society, often promote strong in-group feelings and a network of mutual aid.

The Leaders

Well-trained competent staff are as necessary for parent education as for other services. However, there seems to be some disagreement as to what constitutes a well-trained parent educator. A number of persons, for example, made such comments as "of course only a trained home economist (or "social worker," or "family life education specialist," or "adult educator," or whatever discipline corresponded to that of the respondent) could possibly do an adequate job." However, no matter what the profession espoused, those with successful programs usually agreed that parent educators with the following characteristics are most successful in working with low-income families:

- A mature capacity for "motherliness"—the ability to give and forgive, to support, to guide with clarity and patience, and to set firm limits with both sensitivity and conviction.
- A sense of dignity which carries with it an aura of competent strength, but also permits its owner to perform unpleasant tasks (such as cuddling a messy baby) without loss of dignity.
- Creativity, flexibility, and a willingness to be something of a "maverick" in one's own profession.
- Ways of dress and grooming which can make the group members proud of, but not overwhelmed by, their leader, and present a role model they can realistically hope to emulate.
- Enthusiasm for living and an abundant supply of physical energy.
- An ability to translate intellectual material such

as concepts of child development into practical experiential terms.

- Understanding of the psychological and cultural characteristics of people, both as individuals and as group members.

This last capacity is reported as a product of both specialized training and the total personality of the "trainee." Some agencies have found persons who seem to have a natural gift for parent education from among schoolteachers, caseworkers, home economists, agency volunteers, and housewives in the neighborhoods being served. Thus there is a wide variation in educational background among the leaders, but this is complemented by competent supervision, in-service training, and further formal education. Most of these "naturals" have raised families of their own and out of their experiences bring a sympathetic, pragmatic, nurturant approach to their work.

Although some of our respondents suggest that parent educators who work with low-income families are most effective when they, too, come from a less than middle-class background, others do not agree. What seems to be more relevant than background in the parent educator are: flexibility and perceptiveness in learning from group members what values, customs, and attitudes are important to them.

Low-income families who have experienced social rejection are apt to be especially parochial about where they feel free to assemble. Therefore, meetings held in facilities in the immediate neighborhood, such as settlement houses or public housing projects, are apt to be the most readily accepted.

In some instances, as members feel more at ease with one another, meetings are held in their respective homes. When this occurs the leader subtly guides the hostesses through the intricacies of unaccustomed entertaining, at the same time guarding against the development of competition between hostesses.

Referrals for Service

A number of persons pointed out that group education is only part of a network of services needed by disadvantaged families. Stressing the importance of readily available individual counseling, they reported that while the majority of group leaders provided a certain amount of informal, individual counseling themselves, some parents needed more intensive, individual help than the leaders had the time—or in some instances—the skill to give. Some of them raised the question as to whether it was wise for a person to try to function in the role of group educator and of personal counselor simultaneously.

Referral for individual counseling seems to go most smoothly when a caseworker is a staff member of the agency which employs the parent educator. Then, the caseworker may join the group from time to time, giving the group members a chance to know her so they will feel more secure in accepting a referral for counseling; and the counselor and parent educator may more easily work closely together.

Some persons reported that referrals to outside counselors are more apt to "take" if the group leader accompanies the client to the counselor's office for the first visit. This type of protective guidance seems to help shy or distrustful parents to find their way to community services which they may have previously associated with a threatening and unpredictable outside world, including public assistance agencies, courts, hospitals, mental health clinics, literacy classes, and so on.

Who Participates

Unfortunately only a small proportion of mothers in low-income neighborhoods where such parent education programs are offered actually become involved in the programs. Aside from limitations of staff time and energy, factors in many otherwise potential participants operate to limit the programs. Parents who are not usually reached by the group educational approach seem to include the following:

- Persons whose life experiences have led them to become resigned to hopelessness and failure.
- Persons severely handicapped by physical or mental illness or defect.
- Persons who are so shy and withdrawn that they cannot bring themselves to face a group.
- Persons who because of their extremely hostile and aggressive behavior prove to be too much for other group members to bear.

However, in some cases of both extremely shy and highly aggressive persons, skillful group leadership or individual counseling, or both, have modified their behavior sufficiently to enable them to participate in the group. "Doing" programs, we were told, lend themselves especially well to this kind of behavioral change. The timid mother hides behind her cooking or sewing and quietly gains self-confidence through group-recognized achievement; and the assertive mother is helped to channel her aggression through challenging work projects.

Some, but not all, of the sponsoring agencies carefully plan the composition of their groups to keep a balance in ethnic or religious composition or in personality types, or in all of these factors. Some leaders carefully include as group "stabilizers" mature, self-confident, outgoing persons from the neighborhood who act as "natural" assistant leaders.

Even when the leaders are men and the program is built around such male interests as carpentry, mechanics, or athletics, it has been found that few, if any, fathers respond to invitations to join parent education groups. While some caseworkers have had some success in forming a counseling relationship with such men, they report that moving them from a one-to-one to a group situation rarely meets with success. Further experimentation to find ways of reaching fathers is under way in some agencies.

While none of the programs reported to us have been systematically evaluated, parent educators have produced impressive case stories of changes in at least some participants—increased self-respect, improved maternal coping ability, growth in homemaking skills, and skills in interpersonal relationships. They have also described changes within their groups, with participants holding up higher standards for each other in regard to personal appearance, etiquette, responsible behavior, and the like. Some, too, have reported improvement in relations between persons of differing races and religions.

Such observations are, of course, subject to the biases of leaders, other staff members, and observers. Nevertheless, carefully planned and skillfully led parent education groups offered in low-income neighborhoods would seem to have an excellent potential for helping to strengthen family life for some economically and socially deprived families.

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[1] White, Gladys O.; Hill, Alberta D.; Amidon, Edna P.: Improving home and family living among low-income families. U.S. Department of Health, Education, and Welfare, Social Security Administration, Bureau of Family Services and the Office of Education, May 1962.

[2] Parsons, Mabel H.: A home economist in service to families with mental retardation. *Children*, September–October 1960.

[3] Page, Miriam O.: Cohesion, dignity, and hope for multiproblem families. *Children*, March–April 1961.

[4] Rogers, Muriel Nelson: A group educational program for marginally adjusted families. *Social Casework*, April 1962.

[5] Scott, John F.; Freeman, Howard E.: The one-night stand. *Social Problems*, Winter 1963.

[6] U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau: When your baby is on the way. CB Publication No. 391. 1961.

[7] ———: Your baby's first year. CB Publication No. 400. 1962.

[8] Taylor, Katharine Whiteside: A community-wide program of parent education. *Children*, January–February 1962.

HELPING LOW-INCOME PARENTS

II. Through Homemaking Consultants

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THE QUALITY of family life often hinges on the mother's skill in creating a home which provides nurture and a center of gravity for all the family members. When incomes are marginal, the skill needs to be especially sharp. If a mother who lacks education as well as a margin for error in her income has never had an opportunity to develop such a skill because her own mother did not have it, not only she but her whole family is greatly handicapped.

To help such mothers develop the homemaking skills they need, the School District of Philadephia operates a homemaking consultant service, a special adult education program jointly administered and supervised by the school system's divisions of school extension and home economics education. The program is financed by the local school district with some reimbursement from State and Federal funds for homemaking education. The program developed approximately 15 years ago out of a critical need to improve housing conditions in a substandard housing area in the northwestern part of the city. It has grown from a program established primarily to improve tenant-landlord relations to a dynamic force, not only in strengthening individual family life but also in strengthening relations between school and community in nine widely separated neighborhoods.

Nine consultants, each with a background of home economics education, work directly with individual mothers on whatever phase of homemaking is urgently needed to improve personal, family, and community living. All have had at least 2 years of college home economics, in addition to experience in adult education. Three of them have master's degrees and three bachelor's degrees. Their goal is to help the mothers help themselves.

Each of the consultants has her office in the public school in the community in which she works. From there she visits the families to which she has been assigned.

The first visit would appear to many to be purely a social call. In this friendly visit, however, the consultant is sensing the mother's problems as well as her interests. She will find something positive, something favorable to say to the mother, and she will have something to come back for. She may say, "The next time I come I'll bring you a pattern for your skirt." As a result of this personalized, sympathetic guidance technique, the mother herself begins to point out what steps she should take to improve her home situation. One little bright spot opens the door to many more possibilities.

As soon as a mother begins to grasp what the consultant is teaching, the consultant encourages her to join a group of four or five neighbors having similar problems. Meeting in the home of another person who has made considerable progress gives her a chance to see how others solve their problems. In many instances the mothers meet to sew, but as they are sewing they usually get into discussions concerning child care, teenage behavior, money managament, and meal planning.

In addition to working with individuals and small groups, the consultants conduct discussion sessions for large groups of mothers in school buildings or community centers, encouraging an exchange of ideas and giving the mothers a chance to get out of their homes for a bit. Many mothers bring their small children with them.

Most of the consultants schedule an annual homemakers' day in the school building in their community that can best provide for such a program. This provides an opportunity for the mothers to meet with other mothers with like problems and to exhibit some of their work through a fashion show, display of children's toys made from discarded materials, and food exhibits. School personnel and other community leaders become better acquainted with the entire program by attending.

The attitude and manner of approach on the part of the consultant is of major importance. She must be kind and understanding, possess a good share of empathy and be able to present her instruction in simple, clear-cut terms. Above all, she must be a good listener.

Supervision and Procedures

A member of the supervisory staff of the division of home economics education supervises the activities of the homemaking consultants. She meets with the entire group one morning each month, leading their discussions and providing opportunities for updating their knowledge and skills in various subject areas. For example, she recently took the consultants to an upholstery shop in one of the city's technical high schools where they received instruction on reupholstering an armchair. Another morning she took them to a school's homemaking laboratory where they prepared a variety of dishes from the kind of foods provided needy families as agricultural surplus.

These monthly work sessions are also attended by a member of the supervisory staff from the division of school extension, who supervises the group in relation to the school system's adult education policies. Both supervisors, upon prearranged plans, observe consultants at work with their families. At these conferences the consultants talk over the problems they are facing and evaluate their procedures. Representatives from city health and welfare organizations and community leaders are frequently invited.

As each new consultant is appointed, she is given sufficient time to observe another consultant in action, actually spending 2 or 3 days with her. She is also required to study her community. During this time she gets to know the personnel of the local schools, clinics, health and welfare agencies, and shops.

Careful records and schedules are maintained. A card file of families being visited is kept in the school to which the consultant has been assigned. In addition, she sends a schedule of her planned weekly visits, group meetings, and demonstrations to the director of school extension and home economics education each week for the following week. She also sends them a monthly report indicating how many families are on her rolls, the number of families she has visited, the number of new families included, and the number of families dropped, and the community organizations reached. She includes in this report a brief description of her activities and the conditions and progress she has observed.

The Families

Mothers are referred to the consultant for service from a number of sources. One may be the local school, the referring person occasionally being the school principal but more often the school counselor, school nurse, or attendance officer. Other sources of referrals are social or health agencies, churches, and community councils. Many mothers are referred for the service by the local public health nurse, family service worker, public assistance worker, and child welfare worker. In such referrals, the mother is told that the consultant is an adult education teacher of homemaking who will call on her if she is willing to accept the service. Many mothers learn of the program from a neighbor or at the local school and request the service themselves.

The number of families each consultant serves averages 42, but varies with the seriousness of the individual problems and the nature of the community. Some families are dropped from the rolls after 2 or 3 months of guidance because of their quick improvement. Others are carried for more than a year.

The majority of the mothers visited are extremely poor managers and housekeepers. Their homes are cluttered, poorly furnished, and dirty. Children are many and are inadequately fed and clothed. While the handicap of insufficient income to meet basic needs is often real, the mothers do not know how to spend what they have to the best advantage. About one-third of the families are fatherless.

When a referral is made to the consultant, it usually means that help is needed in money management, meal planning for good nutrition, improved practices in child care, clothing care, and housekeeping.

About a year ago, the director of school extension received an urgent call from the Philadelphia Housing Authority requesting the services of a homemaking consultant for 15 families who were about to be evicted from one of the public housing projects because of their poor housekeeping. Because of the difficulty they would have in finding another place to live, the managing director wanted to give them a chance to stay if they would take advantage of an opportunity to learn, through the homemaking consultant's help, how to "clean up, fix up, and keep up" their apartments.

A homemaking consultant was assigned to work with the 15 mothers at the project each Monday for a full day for 5 weeks. In the morning she gave discussion-demonstrations to the group as a whole on such subjects as the importance of cleanliness—especially in connection with food handling, the refrigerator, closets, the stove—during which she would point out the satisfaction a clean, orderly, and attractive home brings to everyone in the family. In the afternoon, she visited individual apartments, working along with the mothers on their "operation cleanup." At the end of the 5 weeks, enough improvement had been made in 10 of the homes that the families were allowed to continue to live at the project. Five families were evicted.

The failure of some families to respond to their efforts is one of the disappointments the consultants have to face. Most of the families served respond in some measure and continue to put into practice what they have learned. However, each of the consultants has had to discontinue work with some families because of their unwillingness to cooperate.

Some Problems

The consultants often find themselves faced with urgent problems such as helping families to obtain quickly needed housing, food, and clothing. Consequently, they have learned where in their particular communities they can send families for help. Goodwill Industries and The Salvation Army, for example, have provided beds, chairs, and clothing which the consultants have helped the families make usable and even attractive. Referring low-income families to the welfare department for U.S. Department of Agriculture surplus foods has helped family budgets considerably. Helping large families to find adequate housing is often a more difficult problem. The public housing projects are frequently unable to accept families with eight or nine children because they have only a few dwelling units with more than three bedrooms.

Nutritional problems are among the most common problems affecting children in the homes visited by the consultants. Their stress upon the importance of a good breakfast is often effective. School nurses have reported that there are fewer "tummy aches" and headaches when the consultant has succeeded in convincing the mother that children must begin the day with breakfast.

The consultants' efforts to teach families how to use the surplus foods (cornmeal, powdered milk, dried eggs) to best advantage have helped families stretch their budgets as well as to achieve better nutrition. Demonstrations in their use, providing simple recipes, and giving the mothers an opportunity to taste the finished product have resulted in better meals in many families. When this is so, the children get more milk because of the various ways in which the powdered milk is used in cooking.

The Smiths are an example of one family which is eating better because of a consultant's help:

A school nurse, discovering that several children in the Smith family were suffering from malnutrition, arranged for the homemaking consultant to go to their home. When the consultant called on Mrs. Smith, she introduced herself as the homemaking teacher for adults from the school, about whom the school nurse had spoken, explaining that she frequently helped parents follow the recommendations given by the school nurse or doctor in regard to feeding their families the right foods for good health. She found that Mrs. Smith was struggling to care for nine children on about $200 a month.

The consultant worked closely with Mrs. Smith for several weeks. Together they figured out a food budget which would allow for inexpensive yet nutritious meals. She taught Mrs. Smith how to use the surplus foods she was receiving from the welfare department and how to market more wisely. In 2 months' time the children had gained weight, and because of improved health generally, their attendance at school had remarkably improved. At the same time, Mrs. Smith's housekeeping practices had taken a decided turn for the better.

In recommending basic foods the consultants avoid stressing one particular dish. Instead they suggest a wide variety of ways in which each type of food can be prepared. In introducing a food new to the family they prepare it along with a favorite dish in an effort to break down resistance to unfamiliar foods.

The consultants also report good results from their counseling in respect to overweight children, especially preschool children and teenagers. In such cases they help the mothers plan well-balanced, lower-caloric diets. When a school-age child is involved, the school nurse, classroom teacher, and the consultant work together on the case.

Lack of adequate clothing for children is a common problem among the families served by the consultants. Probably their greatest activity in the homes is showing the mothers how to mend, remake, and alter hand-me-down clothing from older brothers and sisters or adults. The mothers show pride in such conversions as the following: a jumper for a teenager from a dress given by a friend; blouses from men's shirts; pants for a 6-year-old from a size 40 skirt; dresses for children and for themselves from inexpensive materials.

A homemaking consultant from Philadelphia's school system helps a mother learn to make slipcovers for her home.

As the consultants help the homemakers sew, they gain their complete confidence. When they have thus established a friendly, understanding relationship, they find they can approach many problems that they could not previously have brought up with the mother. For example:

The nurse and counselor at the school asked the consultant to visit Mrs. Y. The consultant found Mrs. Y and her family of four children living on public assistance in one of the smallest, dirtiest homes she had ever visited. Mrs. Y's housekeeping was very poor, but she was not interested in improving it. The consultant had to reach the mother through her one and only interest, sewing. Mrs. Y had a sewing machine and somehow was able to get enough material to make her own and her children's clothes. Even if there was little or no food in the house, the children were well dressed, but they were rarely clean. To win the mother's confidence, the consultant showed Mrs. Y how to use shortcuts in making garments and perfect her sewing techniques. Then over their sewing she discussed some of the other activities she and several other mothers were doing together, such as seeing to housecleaning "musts" for home safety and health, and planning meals. The consultant hoped that Mrs. Y would show some interest in cleaning her home and giving more attention to planning and preparing nutritious meals, and after a few visits when Mrs. Y did not respond to her suggestions along these lines, she said that she could not continue her visits unless some improvement was made in housecleaning.

The consultant did not call at this home for 3 weeks. She returned, however, after she received a phone call from Mrs. Y asking for help in managing her income and her time. The consultant is still working with this family. Progress is slow, but as long as Mrs. Y wants help and shows some improvement, help will be offered her.

When the consultant is asked by a social worker or a public health nurse to visit a family, she meets with the referring person at a place other than the home of the family to discuss the case and how she might make the best contribution to the family. The two workers make every effort to avoid duplication. Should the consultant find that the nurse or the social worker is in the home when she makes her call, she leaves immediately. They do the same when they find the consultant in the home.

Just as the social worker calls upon the homemaking consultant to help the family, so does the homemaking consultant call upon the public welfare agency, the public health nurse, or family or children's services when need for them is apparent. The consultant attends meetings of community councils and of social and public health agencies. In so doing, she learns how the families she is working with are being helped by others. She also reports progress she has made.

Should the consultant suspect neglect or abuse of children in one of her families, she calls this to the attention of the person who referred the family to her, relying on the referring agent to take what steps are necessary.

Evaluating the Program

While this program surely offers fertile ground for scientific research, none has as yet been attempted. Informal evaluation takes place, however, from day to day. It is provided through self-evaluation by the consultant and untold expressions of appreciation by school personnel, social workers, and community leaders.

Success can be measured in some degree by the change in personal, family, and community living patterns that take place following the service provided. The consultants use the following list of questions as their yardstick for determining effectiveness:

- Have there been improved relationships among family members?
- Do all family members share in the work of the home?
- Do families take pride in their home?
- Do family members sit down to meals at regular times?
- Is there family planning for spending and saving?
- Do family members take the initiative in solving their own problems?
- Is better use made of leisure time?
- Has there been an improvement in the health of family members?
- Is there evidence of improved citizenship on the part of family members? (clean, well-kept homes? tidy yards, front steps, pavement? rubbish disposed of according to city regulations?)

Rarely in their past have the mothers in the homes visited by the consultants attended the meeting of the home and school association or adult education classes in the neighborhood school. After they have been helped individually in their own homes and a certain degree of "order out of chaos" has developed—clothing is in good wearing condition, and relations in the family and the community are improving—many of these women begin to relate to their neighbors, to the community, and to the school.

Thus the value of the program reaches from the home out into the community and the school. Its success is reflected in the improved appearance of the homes in the community, in the cooperation of tenants and landlords, and in the willingness of the people to assume their share of community responsibility and work for the solution of community problems.

It is only with respect to the poor that our society regularly and harshly makes the distinction between those who are deserving and those who are undeserving. We do not take money away from the idle rich because they don't deserve it or don't use it well.

Dr. Charles Frankel, professor of philosophy, Columbia University, at the National Social Welfare Assembly Annual Luncheon, December 1961.

CHILDREN'S RESPONSES TO THE NUCLEAR WAR THREAT

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WE KNOW that environmental factors, specifically the social environment, play a large role in determining not only attitudes and patterns of behavior, but also the psychological structures that influence the development of character. The nearly universal recognition of a potential or, as many people think, actual threat to the continuity of human civilization and to the integrity of our biological habitat is a change in the social environment which ought to make a difference to the mental content, and thus the psychological experience, of children. On the basis of preliminary observations I have formed the conviction that the profound uncertainty about whether or not mankind has a foreseeable future exerts a corrosive and malignant influence upon important developmental processes in normal and well-functioning children, as well as in those who are in any case vulnerable to additional stress due to preexisting psychopathology. In my view, the subtle and pervasive effects of the present social climate upon all children represent a far more serious hazard than the incidence of heightened anxiety and of fear which children share with adults at moments of political crisis. In this paper I shall present some facts and some ideas in support of this conviction.

Before turning to the data, I want to point out that the exploration of the psychological consequences of such a crisis, important as it may be, is a secondary response to the actual threat to survival. If there is a real possibility that nuclear weapons will be used, with disastrous consequences for people everywhere and for all future generations, a preoccupation with the psychological aspects of the threat is trivial. It is as though people in a house afire were to spend their time reassuring the children instead of putting out the fire. In our role as professionals and in our capacity as citizens, the primary task is social action to forestall a nuclear war and to work toward a livable world. However, I believe that it is possible to combine a primary commitment to necessary social action with an interest in identifying and counteracting malignant psychological aspects of the immediate situation.

There is strong evidence that many children are aware of the existence of nuclear weapons, of political tensions, and of the apprehensions felt by the adults with whom they live. We know less, however, about what this information means to children and about whether or not it makes a significant difference in their lives. Therefore, an informally constituted group of colleagues in New York City, which calls itself The Committee on Children, decided to obtain factual data on children's conscious awareness of the world situation and on their attitudes toward it. Since the spring of 1962, this group has been developing a questionnaire to be administered to large numbers of children in many parts of the country. This article, however, can report only on what was learned from pilot studies.

In these pilot studies we experimented with four different versions of the questionnaire. The study samples were drawn only from the Greater New

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Based on a paper presented at the 1963 annual meeting of the American Orthopsychiatric Association, Washington, D. C.

York area. Data were collected during the summer of 1962, well before the Cuban crisis, and during October and November 1962, and February 1963. Because of the variation in the form of questions and the limitations of sampling, no general conclusions can be drawn from our material, not even about New York City. However, it remains of interest to know what children did say when asked their expectations of the future.

The present report is limited to the responses of 311 children between the ages of 10 and 17 years who were from widely different socioeconomic groups. Over 100 questionnaires were obtained through schools and community centers serving grossly underprivileged areas with large proportions of Puerto Rican and Negro children. Another third of the sample was obtained from schools and camps attended by children of lower-middle and middle-middle socioeconomic groups. And the remaining 100 questionnaires were obtained through private schools, one of them under religious auspices, which serve intellectual, cosmopolitan, upper-middle-class families.

We wanted to find out whether children's spontaneous and overtly conscious expectations in relation to the future are significantly affected by the nuclear danger. We realized that unconscious expectations or fears may be potently at work which might not be reflected in the children's answers, and that children also may not communicate conscious but anxiety-laden thoughts about the future. Nonetheless, conscious and communicable aspects of mental life carry a great deal of weight and are important. The effort was to get children to express their rational expectations about the future and to ask our questions in a way that would not suggest a direct reference to war or to the political situation.

What Children Expect

The kinds of questions we asked were: "Think about the world as it may be about 10 years from now. What are some of the ways in which it may be different from today?" Also: "How would you like it to be different?" And also: "If you had three wishes, what would they be?"

As can be imagined, we obtained fascinating material on children's visions of expanded space and of an automatized world. Interplanetary travel, space stations, trips to the moon, flying cars, machines for all possible purposes (including one, described by an 11-year-old, in which "you push a button and it tells you what you should do that day"), and robots loomed very large. In addition, nearly all the children expressed the universal wish for a long life or immortality, and for lots of money. A great many spoke of miracle cures for fatal diseases, of better living conditions, of an end to racial discrimination, of better education and housing, and of more kindness in the world. Among the underprivileged city children there was a surprisingly strong emphasis on beauty and cleanliness. These children revealed longings for beautiful houses, clean streets, flowers, country life, and contact with animals, as well as urgent concerns about jobs, health, school grades, bicycles, and enough food.

How much room did all of this leave for larger concerns in behalf of the future? Of these 311 children, 218 (or 70 percent) mentioned the issue of war and peace. In all but a few instances, this was more than a pious wish for world peace. Many of the children wrote of what war would mean, of how and why they thought the world would arrive at peaceful existence, and of the main obstacles to peace.

As one would expect, the undereducated children from marginal social groups were neither as articulate, nor, as a group, as preoccupied with the danger of war, as the middle-class children of comparable ages. With the exception of a small group of 12- and 13-year-olds from a district in New York's Harlem, the most pessimistic children in the samples, the frequency with which the problem of war was discussed was lower among the poor children. Of the underprivileged groups (excluding the Harlem sample), 39 percent mentioned the possibility of war in speaking of their future. For the lower-middle-class group, the corresponding value was 62 percent; and for the middle-middle- and upper-middle-class groups, the corresponding values were 77 and 100 percents.

However, if one turns to what these children have to say about the topic, once they do mention war it turns out that the underprivileged groups are at least as pessimistic as the others. Of those who mention war, 35 percent considered a destructive war very possible, and some thought it a certainty. A young Puerto Rican wrote: "I think I would be all broken up because of the war which will come. The war destroys New York." Many children perceived a decisive alternative. For example, in discussing what the world would be like in another decade, one 12-year-old wrote: "We may have gone to the moon. We would maybe have a new way of transportation. Maybe we will not even be here 10 years from now. Maybe there will be no such thing as a world. Maybe there will be a world war III. We don't know."

In comparing the responses from the socially deprived groups with those from the middle-class groups, we find that many of the deprived children are so preoccupied by immediate pressing concerns, such as poverty, worry about school grades and jobs, and hostile elements in their immediate situations—such as gangs—that they have less "room" for the contemplation of more remote dangers. Not unrelated to this is the circumstance that many of these children are cognitively impoverished and so envisage the future only in immediate terms. However, once such children do recognize the danger to mankind's future existence they are more inclined to view it fatalistically and pessimistically. They express a wish for peace, but often no notions of how it might come about and relatively little expectation of a positive solution.

As already mentioned, some of the data were obtained before the Cuban crisis; the remainder, shortly afterwards. One would expect that the tension during that week of October 22, 1962, would have greatly reinforced children's awareness of the possibility of war. In many ways it must have done so, but this is not revealed in our questionnaire. Of the 55 children who responded while at summer camps, well before the October crisis, 79 percent discussed the problem of peace and war, and of these, 34 percent envisaged a destructive war as entirely possible and, in some instances, as probable. The reader will remember that during the summer of 1962 the question of shelter building received much heated discussion. It is my impression that, in New York City at any rate, the shelter controversy strongly impressed children with the possibility that they and their own homes might be endangered by powerful atomic weapons. At any rate, for the children in our sample the concern was as great before the Cuban crisis as it was afterwards.

War and Peace

By and large, the 218 children who mentioned the possibility of war also committed themselves to a probability statement. I have already cited some examples of the extremes, a firm expectation of war or, more frequently, a decisive either-or statement. Here are some others:

- To a question of whether anything could be done about keeping the bad things from happening, a 12-year-old answered: "No, because all of the people will die and the world will blow up."
- A 14-year-old speculated that 10 years from now the world could be "completely united—and have no danger of war"; but added that "if there was war before then, the world could be almost completely destroyed with no certain power but just poverty stricken countries."
- Another 14-year-old wrote: "Either complete peace or total destruction."
- A 13-year-old: "Red China is going to become more powerful than any other country and they'll probably find the atom bomb and bomb the world." This child also wrote: "I feel that man has enough trouble surviving on earth and why should they [literally] seek for more problems."
- Another 13-year-old: "I think if there is a world 10 years from now it will be horrible and full of fear from war (with whatever weapon they have invented by then)."
- An 11-year-old thought the world would be "more modern (if we aren't wiped out by the bomb first)."

An Unpleasant Future

Many of the children who did not believe that a war is apt to occur within 10 years, nonetheless envisaged a remarkably unpleasant future. For example:

- A 14-year-old wrote: "The people of the world never change, but the atomic powers will still be expanding and the threat of war and complete destruction will hang as a cloud of fear over the world. And people will have to live with the fear of death eventually by the instruments of war."
- An 11-year-old: "In 10 years countries will still be quarreling—larger countries will be preparing bombs to wipe out the world."
- Another 11-year-old: "The people will be living underground and they would have to have a lot of light or I think the children would not be very strong as they are now. But I really hope it will be a lot better than I think it will be."
- A 10-year-old: "There wouldn't be any schools or houses and people would live in the ground. They would be different colors and have long feet and long hands. That's what I think the world will be 10 years from now." In response to the question of how she would like it to be different, this child replied that "it would be peaceful and happy."

The older and well-educated children displayed their pessimism in sophisticated ways:

- A 14-year-old first described medical advances and continued, "yet as far as the world situation is concerned tension will be much worse." He explained that Red China will have the bomb and will expand, that Russia will be unable to control China, and that the underdeveloped countries will turn to communism. American politics, he thought, would turn more to the right as the world situation worsens, and he concluded that "great powers would continue to pollute the atmosphere with test bombs."

A large proportion of the questionnaire answers obtained from the older, middle-class children, especially those in private schools, turned into essays of this sort which, in totality, touch upon almost every aspect of the war and peace problem. Disarmament, the United Nations, a world federation, the World Court, the economics of conversion to nonmilitary production, the changing balance of power among nations, ideological conflict, moral and religious concerns, and the psychological roots of aggression all were mentioned, and frequently discussed very sensibly.

Also interesting is what these children said and implied about the causes of danger, and about the changes required to make peace possible. Only 11 children (or about 3 percent) gave evidence of a mechanism, apparently more common in other groups, of projecting the blame for danger on communism (or on Khrushchev and Castro personally); and even these expressed sympathy with the people in Communist countries, with the hope that they will become free. The vast majority of the children saw the problem of achieving peace as the necessity for nations and people to get along, always including this country in their demand for finding peaceful solutions. The younger children, and many older children from depriving backgrounds, seemed to regard peace as a matter of personal friendliness and intention. A good many children responded in a similar vein as the 10-year-old who wrote: "I wish Russia and Cuba be our friends."

The older and more sophisticated children recognized conflicting interests and the need for legal and military mechanisms to maintain peace. Most of them were critical of the power needs of large countries, often including our own. Here are some examples:

- During the second week of October 1962 (just before the Cuban crisis), an 11-year-old wrote: "I would like Kennedy and Fidel Castro to become good friends and both countries start to live together and we shouldn't have war—and there will be no more fighting and that we would not have to live underground."
- Another 11-year-old answered the question "Is there anything that can be done to keep the bad things from happening?" with "Yes, by making friends with other countries, that's why we have United Nations."
- A 14-year-old: "I would like to see the 'big 5' sit down and discuss the world situation with good results . . . and we could all live with no threats of bombs hanging about our heads."
- A 13-year-old said he would like new leaders and "a peace organization better than the U.N." "If East and West cooperated," he continued, "medicine and space science would improve and warfare would fall into the past."
- A 14-year-old: "I would like to see the U.S. and U.S.S.R. friendly and all their scientists working together for the good of mankind."

All of the foregoing quotations about cooperation come from public school children. The private school youngsters, generally more sophisticated, expressed the same sentiments but were far more knowledgeable about problems of disarmament, negotiation, peace movements, and the economic sources of conflict.

Some Implications

It is tempting to continue with the questionnaire material, for as one reads dozens and hundreds of these answers, one accumulates a powerful impression of troubled and wistfully hopeful children. The question "How would you like it to be different?" particularly seemed to invite the indirect expression of fears and dissatisfactions. It is in response to this that children expressed their hopes that there would be no more fear of bombs and radiation, that people might not be hurt, that there would be less fighting, less poverty, better treatment of Negroes, and so forth.

However, a few things must be said about the implications of these expressions in relation to the development of children. Developmental psychology has begun to make explicit some of the ways in which children internalize and make part of themselves what they learn from adult models. We think that certain patterns of adaptation characterize each major developmental stage. And by the same token, we think that each phase of development is especially vulnerable or sensitive to particular aspects of the outer world.

For the school-age and adolescent stages, to which this discussion is limited, the central developmental processes revolve around the mechanism of identification and the establishment of personal identity—related but not interchangeable concepts. Identification is a dominant mode of middle childhood, whereas identity formation is the integration and synthesis of all past identificaions into a cohesive sense of self and of one's place in the scheme of things. As Erik Erikson has pointed out, much of adolescent development can be understood as the struggle to achieve a sense of personal identity.[1] I believe that a consciousness of nuclear danger necessarily weakens and impedes the most useful and constructive processes of identification in school-age children and that it tends to distort normal processes of identity formation in adolescents.

Granted, patterns of family living as well as the broader social scene have always contained disruptive elements. Long before nuclear weapons were ever dreamed of, both constructive identifications and an acceptable identity were hard to come by—the psychiatric clinics, the hospitals, the schools, and the courts are witnesses to the many many failures of development which our society has produced. My hypothesis is merely that the changes in the social milieu and within individuals that occur in the wake of the nuclear crisis are of such a kind as to make still more difficult developmental progress in these two areas.

To be specific, though necessarily schematic: School-age children are profoundly aware of their status as children. This status means to them not only that they are as yet dependent and unable to compete with adults, but also that they are in the process of growing and of learning to become adult. Their image of what there is to be learned, of what it means to be an adult, of the attitudes, skills, and attributes of successful living all come from what they see and sense in their elders. As we know to our cost, they identify not only with that which makes a powerful positive impression—courage, lovingness, skill, and learning—but also with painful and hateful components in the personality of those who loom large in their lives. The sons of ineffective fathers may desperately strive for strength and masculinity, and seize upon teachers, public heroes, or any other models as identification figures. Yet, at the same time, they may come to feel unconsciously that in becoming a man and a father, they are doomed to become as weak and ineffective as their own fathers. In short, those identifications that have adaptive value and that are strengthening to the child are derived from models who actually possess useful virtues and successful kinds of competence.

Following is an oversimplified version of what can happen to children's identification figures as a result of the nuclear threat:

Children know that an overwhelming danger exists. They also see that parents, teachers, in fact all adults, feel inadequate to cope with this danger. Even the most affirmative supporter of action for peace cannot assure children of his complete confidence in a livable future. This is an unalterable fact, as long as nuclear weapons exist.

Most children also see in their elders most of the time evasion or lethargy based on underlying fear and fatalism—and children are known to be sensitive to underlying feelings and to unconscious defenses that operate within adults. Other children see helpless anxiety and manifest despair in adults who have become keenly concerned. Only rarely can children see a resolute facing of the problem, clear-cut convictions, and deliberate action even without assurance of success. And many children who do observe a firm stand in their elders are given a demonstration of hatred and scapegoating as the only solution. To judge by some newspapers and public utterances, the way to stay alive is to trust no one and to destroy your opponents before they can destroy you.

These are far from optimal patterns of identification. While they may serve as a protection against anxiety on one level, they generate anxiety on another. For surely the image of the world they suggest, and of how to survive in it, is ugly and uninviting.

Effects on Adolescents

Following is an equally oversimplified formulation of the adolescent struggle for identity:

Adolescents must attempt to reconcile strong impulses from within, with all they have learned about themselves, about reality, and about the larger social framework in which they live. Inevitably, their better acquaintance with the adult community, with adult values, and adult traditions leads to disappointment and rebellious criticism. However personal and immature the reasons for adolescent scorn may be, young people have a keen eye for the shortcomings and inconsistencies of adult society. The hypocrisy and selfishness and emptiness of which adolescents have complained since time immemorial really exist. And if it were not for young people, and for those who in their youth acquire enduring altruistic attitudes, society would lack a most important impetus for progress.

Under ordinary circumstances, adolescents become young adults and achieve a more objective perspective largely in response to the realistic opportunities for the satisfying experience which society offers. There *are* opportunities for learning and teaching; scientific advances *are* exciting; happy relationships among people *are* possible; there *are* jobs, potential sexual partners, and opportunities of many kinds. It is not required that these satisfactions be guaranteed. Young people come to terms with the adult world as long as it holds out a reasonable promise for fulfillment in some spheres of living. Adolescent growth is largely a matter of the pull exerted by the prospect of maturity, pitted against remaining needs for dependency and the security of childhood.

But if there is no future to look forward to, or if it seems chiefly disastrous, where is the pull for maturity to come from? The responses to our questionnaire leave little room for doubt that recognition of the threat to survival is of vital moment to children at this critical stage of development. And what I have already said about identification figures for middle childhood can also be said about the adult value systems exhibited to adolescents. Adolescents today can find more than ordinary cause for profound distrust of adult standards of thought and behavior. It is as though the wildest adolescent fantasies of adult insufficiency had suddenly come true. For they feel that it is we adults who brought things to such a pass, and who are not about to better them.

Elsewhere I have discussed another adolescent reaction to the world crisis, which has also occurred.[2] It consists of an alliance between young people and those elements of adult society that do assume an active and consistent stand in relation to the issues of peace and of human betterment. The formation of personal identity can, under some conditions, find its focus in this issue.

Our study presents no conclusions, but the alternatives that emerge were well expressed by two of our young respondents. One of them laconically replied to the question about what the world would be like 10 years from now: "We be dead." The other, an adolescent, gave as his first and foremost wish: "Valid reasons to believe in future progress, not regress and destruction for myself and the world."

Let us listen to the children.

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[1] Erikson, Erik H.: The problem of ego identity. *Journal of the American Psychoanalytic Association*, April 1956.

[2] Escalona, Sibylle K.: Unpublished paper delivered before the William Alanson White Psychoanalytic Society, New York. November 1962.

I suggest that it [the family] can regain its moral authority, not by reinstating the authoritarian role it once occupied, that is gone forever, but by the direct involvement of parents in the moral and political issues which are shaking the world. . . .

We have seen the young Negro in the South asserting a moral leadership without aid from his family, his school, or his elders. We have seen white students going to his aid, often against the wishes of their families, always against the pressures of their society. We have seen young people volunteering for the Peace Corps, forming their private peace corps projects, responding to the idea of a domestic service corps, ready to serve humanity at the point of its greatest need.

. . . The hunger for nobility, for the "rare words and facts that harmonize simplicity and truth," is a reality for them, and the nourishment of their spirit will come from those who care to involve themselves in the struggle to solve the problems of survival, liberty, and fraternity. In seeking to become worthy of the respect of mankind, the citizen-parent becomes worthy of the respect of his children. . . .

Harold Taylor, vice president, the Peace Research Institute, at the 75th anniversary year conference of the Child Study Association of America, March 1963.

Studies of pica in children
throw light on . . .

WHY CHILDREN EAT THINGS THAT ARE NOT FOOD

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FOR THE PAST 8 years the Children's Hospital of the District of Columbia has been conducting studies of children with pica—a craving to eat bizarre substances not intended as food. The studies grew out of concern about an increasing number of cases of lead poisoning in preschool children.

The children with lead poisoning were treated with efficient methods of removing the lead from the body, and their parents were repeatedly warned not to permit their eating lead-containing substances, such as plaster and paint from walls. Nevertheless, many of the children were brought back to the hospital later with lead intoxication, some of them with growing evidence of resultant brain damage; some with already developed permanent convulsive patterns and severe mental retardation. Thus it became increasingly evident that lead ingestion was a public health problem, the solution of which would require investigation of why these children were eating these lead-containing substances in the first place.

Therefore, the hospital planned an investigation of pica in children, with five research goals:

1. To trace out the natural history of pica as a phenomenon.
2. To describe the emotional climate in which this condition develops and flourishes.
3. To determine the relationship of pica to nutritional disturbances in the affected children.
4. To find out whether there are cultural aspects.
5. To delineate implications for prevention.

The investigations were carried out by an interprofessional research team consisting of a psychiatrist, pediatrician, psychologist, and social worker. They were assisted in investigating the prevalence of pica by the nurses of the District of Columbia Visiting Nurse Association, who inquired about the problem of all mothers of children from 1 to 6 into whose homes they went for any reason.

Ninety-five of the children from our pica clinic, 36 with lead poisoning, were studied intensively in the psychiatric phase of the research. However, the studies could not be completed on some of these children since their mothers failed to bring them back to the clinic even for medical followup. There is reason to believe that the children who were studied may represent milder cases of psychosocial pathology than those not included.

This phase of our investigations involved a control group of 27 normal children and 32 children with psychiatric diagnoses. It consisted of—

- Interviews with the mother and (in some instances) the father.
- Psychological testing of the child by the clinical psychologist.
- A playroom interview with the child by the psychiatrist.

- A Rorschach test of the mother if she was willing to participate; 115 of the 145 mothers of the subjects and the controls were willing.
- Interpretation to the parents by the psychiatrist after the research team had conferred to summarize the psychodynamics involved in the child's pica and to consider the most feasible ways of approaching the problems.
- Followup of a number of the children for several years after the original study through the pica clinic. In this followup, the medical, psychological, and social problems were reevaluated. The social worker provided casework service to some families over extended periods. Seventeen of the children with pica and seven of the children who were psychiatric controls received psychotherapy.

Nutritional studies were made on 78 children, 28 of whom were controls. They included a number of items pertaining to both social history and psychological data, where data comparable to the psychiatric studies were obtained. Observations made on the children at play through a one-way screen revealed not only whether or not they had pica and, if so, to what extent, but also verified some of the findings of the psychiatric study.

While stimulated by the medical problem of lead poisoning, the investigations soon revealed that children with lead poisoning represented only a small portion of those having pica. In fact, it was found that 50 percent of the children hospitalized for so-called accidental poisonings had persistent pica.

History and Incidence

Most children begin mouthing objects in the middle of their first year as part of the normal hand-to-mouth stage of development. Child development studies indicate that this type of activity subsides early in the second year of life. Its persistence as a major activity past 18 months of age may be considered in the abnormal range, but pica involves a further step—the developing of a craving for actual ingestion of a particular substance. The 500 children we studied with this condition habitually ate such substances as newspaper, toilet paper, cleansing tissue, dirt, plaster, wood, cigarettes, matches, starch, paint, powder, crayons, grass and leaves, soaps, bugs, and other objects. The craving for such unnatural "food" is symptomatic of an unmet need.

In a random survey of 859 children, it was found that pica as a symptom occurs chiefly in preschool children, the greatest incidence occurring in children between 18 months and 2 years of age. In lower socioeconomic groups the incidence among children in this age group is between 50 and 60 percent; in higher income families, about 30 percent.[1]

After 2 years of age, incidence drops. By 3 to 4 years of age the manifestation seems to be mostly given up as a persistent habit by children of the "private patient" economic level, while it continues to be evident in about 20 percent of the Negro children of lower economic status found with this condition. Pica does not usually occur in persons past 6 years of age, with notable exceptions such as organically damaged or schizophrenic children, pregnant women, and women in some subcultural groups. It seems to be substituted for by other behavioral and somatic manifestations when the psychological need for symptoms persists.

The Emotional Climate

Through our various investigations we have come to see pica as a result of interaction between forces acting within the child and in the environment.

The dynamic forces within every child at birth include a very necessary investment in oral activity. This varies considerably in strength from child to child. Some children show more interest in mouth activity than others. Some children may have such interests enhanced by the way their mouth activities are dealt with by adults or even other children, particularly their siblings. Once there is an intense pressure for oral stimulation in the child, its fate and manifestations are determined by the way in which it is dealt with from the outside.

Since there is a normal tendency for mouth activity, mouthing and ingestion of all types of materials are to be expected on an experimental basis in the normal hand-to-mouth stage of development at younger age levels, which persist when there are extra pressures in this direction. Usually mothers are on the alert for this and will not allow the child to take harmful objects into the mouth, much less swallow them. However, among children with pica, the mothers usually have supplied inadequate patterns of control for these oral activities. The manifestation then may go on to become an internalized one in the child, with the craving often becoming quite specialized to one or a few materials which seem to have acquired specific meaning, usually symbolic to the child. In other words, the child has experienced no conflict between his inner pressures to mouth objects and the forces outside because the forces outside have been nonoperative.

In this frame of reference, our studies[2, 3] thus far indicate four ways in which pica may develop:

1. *Pica may be an attempt by a young child to solve the problem of meeting his oral needs when the mother is unavailable to him because of death or separation or because of personality disturbances in the mother.* In the latter instance, the personality disturbance leading to the mother's unavailability may be manifested as: (*a*) excessive passivity; (*b*) incapacity to relate to the child; (*c*) depression and withdrawal; (*d*) excessive dependency; (*e*) hostile feelings toward the child; (*f*) concern over marital conflicts.

2. *Pica may represent excessive oral gratification resulting from overstimulation by the mother.* This overstimulation may stem from: (*a*) conscious or unconscious maternal satisfaction in the oral activities and appetites of the child; (*b*) maternal disturbances in impulse control (in mothers who may have patterns of addiction themselves) so that the mother cannot deny the impulse satisfaction in the child; (*c*) the mother's expectation that the child will control the mother's own impulses; (*d*) the mother's handling of any anxiety manifested by her child by offering oral activity.

3. *Pica may represent aggression directed toward the mother as a continuation or displacement of early conflicts over feeding, especially around introduction of solid foods.*

4. *Pica may be accentuated or perpetuated by brain damage affecting perceptual and motor development.* This occurs when: the child uses his mouth as a supplementary sense organ to aid him in compensation for distortions in visual and auditory perception; or the mother fails to recognize or is unable to meet the exaggerated dependency needs of the organically damaged child.

In some families the father does the overstimulating which induces the pica. In others, the father prevents the pica by providing controls when conditions are otherwise conducive to pica.

Corrective approaches to these problems are of course based on differential diagnosis and bringing to bear appropriate measures. Except in the less frequent cases of the severely brain damaged child and where the pica is related to a psychosis or deep neurosis in the child, pica responds well and quickly to treatment of the mother through education or psychotherapy, usually carried out by the pediatrician or a social worker.

Of all the maternal personality syndromes conducive to pica, the one most frequently encountered is the combination of passivity and dependency. Mothers with this as an ingrained character pattern are frequently of low socioeconomic status and are rarely readily available to the treatment staff. Their passivity is so great that they cannot reach out to the clinic teams. Therefore, reaching them with appropriate treatment or education means abandoning our time-honored reliance on having mothers come to our clinic. The staff must go to them. Only if ways are found to meet the dependency needs of such mothers can they in turn meet those of the child.

Nutritional Factors

Many writers have assumed that a nutritional deficiency is the major etiological factor in pica. However, investigators at the Children's Hospital could find no correlation between the occurrence of nutritional deficiencies and of pica.[4] They did find, in repeating experiments originally carried out in the Union of South Africa, that intramuscular injections of iron cleared up pica. However, in a controlled experiment in which some children were given intramuscular injections of saline, the Children's Hospital team found as many children were cured with saline as with iron.

Another controlled study employing a multivitamin-mineral preparation showed this to be only as effective as a placebo in curing pica.[5]

Cultural Aspects

Early in our studies it became apparent that pica in the District of Columbia area is especially prevalent among children whose mothers have pica themselves and among children whose mothers have come from communities where clay eating and starch eating are a part of the cultural pattern. This early impression was borne out by the later controlled studies.[6] In general, mothers who came from communities where clay eating and starch eating were common, or who had engaged in pica as adults, tended to have a tolerant attitude toward pica in their children and some even encouraged it.

Geophagy, or clay eating, has been reported to exist in many parts of the world, particularly among primitive people, and is said to have been known among the North American Indians before the time of Columbus. Today it is still found among some poor people, Negroes and whites, in the southeastern part of the United States. Clay eating was common among the slaves in pre-Civil War days, and may have been a custom they brought from Africa. On the other hand, some Negroes may have eaten clay in those days as a means of attempting suicide. The original significance of geophagy faded.

In order to learn more about the cultural aspects of pica, one of the research investigators held group interviews with 16 mothers of children with pica. The mothers were selected as having come from communities where clay eating occurs or as having had pica themselves.

From these interviews, we learned that in different parts of the South different kinds of clay are eaten. The most popular are red clay and white clay, but yellow, gray, and black clays are also regarded as edible.

Clay for eating is obtained from various sources. In some communities it is dug from a pit; in others it is taken from special places at the side of the road, from around the roots of a tree, or from a mine. Sometimes clay which has been used as mortar is dug out from between the bricks of a chimney or fireplace and eaten, its smoky flavor being considered especially good. In large cities clay for eating may be purchased by the sack, but in rural communities each person digs his or her own clay. Some people eat the clay as it comes from the ground, but many prefer to bake it in the oven until it is hard, then pound it into small pieces and eat it.

In the past clay eating was engaged in by both men and women, but now in the South it is a practice found almost exclusively among women and children. Why the habit has been largely abandoned by men is not clear, but some of the women report the impression that there may be more smoking and drinking among the men than among the women in the areas where clay eating is prevalent.

Some women do their clay eating when alone; others prefer to munch on the clay in the company of friends when they are engaging in some activity together, such as a quilting bee. There is general agreement among our informants that clay is not usually eaten because of hunger, for frequently it is enjoyed right after a meal. Many clay-eating women start the habit in childhood, in imitation of their mothers and grandmothers. Others start during pregnancy. Some of the women interviewed described *cravings* for the clay which they are unable to satisfy with any substitutes.

In this country in most places where clay eating is known, laundry starch also is commonly ingested. Some of the mothers whom we interviewed had never eaten clay but had eaten starch since childhood. Several mothers took up starch eating after moving to the District of Columbia, where their favorite clay was not available. One mother, however, gave up the starch eating in favor of smoking. Some who began starch eating during pregnancy stopped after the baby was born; others continued.

The studies of culturally based clay-eating and starch-eating habits and attitudes of mothers who have been unable to resist the cultural influences suggest that for some children these influences may be important in predisposing the child to develop pica rather than to manifest some other behavior problem. In such cases the model presented by the mother would make it easy for the child to learn these patterns, particularly when the mother's attitude toward pica is one of permissiveness or even one of enjoyment in sharing the habit with the child.

As to Prevention

No matter what the pica-genic characteristics in the child's background, pica in children represents a craving early in life which has many of the dynamic characteristics of the cravings which later in life form the basis for the common addictions. Studies are going on to explore such possible correlations. These might possibly lead to awareness of "addiction prone" families.

At the Children's Hospital the adoption of the routine of inquiring in all history-taking about whether the child ingests nonedible substances and of regarding all pica cases as presumptive lead poisoning has resulted in a 300-percent increase in the diagnosis of lead poisoning, mostly before the usual clinical symptoms have appeared.

What we really need, however, is to apply the concept of primary prevention. This means identifying the types of families that are "pica prone" and, long before symptoms can develop, to apply corrective emotional and sociocultural approaches.

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[1] Millican, Frances K.; Layman, Emma M.; Lourie, Reginald S.; Takahashi, Lily Y.; Dublin, Christina C.: The prevalence of ingestion and mouthing of nonedible substances by children. *Clinical Proceedings of the Children's Hospital of the District of Columbia*, August 1962.

[2] Lourie, Reginald S.; Layman, Emma M.; Millican, Frances K.: A study of the etiology of pica in young children, an early pattern of addiction. *In* Problems of addiction and habituation. Paul H. Hoch and Joseph Zubin, eds. Grune & Stratton, New York. 1958.

[3] ———: Emotional factors in the etiology and treatment of lead poisoning. *A.M.A. Journal of Diseases of Children*, February 1956.

[4] Gutelius, Margaret F.; Millican, Frances K.; Layman, Emma M.; Cohen, George J.; Dublin, Christina C.: Nutritional studies of children with pica. I. Controlled study evaluating nutritional status. II. Treatment of pica with iron given intramuscularly. *Pediatrics*, June 1962.

[5] ———: The treatment of pica with vitamin and mineral supplement. *American Journal of Clinical Nutrition*, May 1963.

[6] Layman, Emma M.; Millican, Frances K.; Lourie, Reginald S.; Takahashi, Lily Y.: Cultural influences and symptom choice—clay-eating customs in relation to the etiology of pica. *Psychological Record*, July 1963.

In California a delinquency research project experiments with . . .

ALTERNATES TO INSTITUTIONALIZATION

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THE California Youth Authority, looking for a new approach to the rehabilitation of confirmed delinquents, is experimenting with an intensive treatment-control program in the community as a substitute for the traditional type of institutionalization. This experiment was established in September of 1961 as a 3-year research and demonstration project, jointly financed by the State of California and the National Institute of Mental Health. Located in the cities of Sacramento and Stockton, it is known as the Community Treatment Project, although its official title is: "Comparative Assessment of Institutional and Community Treatment for Comparable Groups of Youth Authority Wards."

The high rate of recidivism among juvenile offenders testifies to our lack of knowledge of appropriate methods for turning delinquents into nondelinquents with or without the use of institutions.

This fact alone would provide adequate reason for this kind of research project. A more pressing reason in California derives from the tremendous population growth which causes the actual *numbers* of youths committed to the State Youth Authority to increase every month, even though a slight decrease in the *rate* of juvenile delinquency has occurred in recent years. If present trends continue, the number of youths placed in California's already overcrowded correctional institutions will double by 1973. To meet this problem by building new institutions is extremely costly and ignores serious doubts about institutions' rehabilitative potentials.

In the Community Treatment Project, an attempt is being made to compare the effectiveness of a period of intensive treatment in the community with a period of incarceration for similar groups of habitual delinquents. Effectiveness is measured by the youth's parole performance and attitudinal and behavioral changes. A second goal is to develop optimal treatment control plans for defined types of delinquents. The question to be answered is: *What kinds of treatment programs in what kinds of settings are most effective with what kinds of juvenile delinquents?*

In accordance with the research design, cases are being randomly assigned to the community program and to the Youth Authority's regular programs from an eligible pool of boys and girls undergoing their first commitment from the juvenile courts. Seriously assaultive cases are excluded from the eligible pool. To date, 96 percent of the girls and 72 percent of the boys having first commitments have been found eligible. Their average age is 16, with a range of from 10 to 18 years. Except for the excluded cases, the eligible group is comparable to juve-

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nile court commitments statewide on such factors as commitment offense, prior delinquency, racial composition, intelligence, family characteristics, school adjustment, and academic achievement.

The community agents have a wide variety of academic backgrounds and treatment skills. This provides a range of available treatments from which to prescribe for a specific case. One case, for example, may require, singly or in combination, individual counseling, psychotherapy, family therapy, guided group interaction, activity group, surveillance and firm discipline, or foster home placement. Cases are discussed intensively by a staff group prior to admission to the project and at 3-month intervals thereafter. Case conferences are attended by a member of the research team and the treatment supervisor, as well as the assigned agent. Each agent carries a caseload of eight cases for intensive treatment. This is defined as two to five contacts weekly and may involve partial or full-day programing for the youth.

To treat in the community delinquents who have been adjudged by county officials as unsuitable for further handling in the existing community programs is obviously a serious undertaking. None of the Community Treatment Project's program elements are in themselves new concepts. Probation and parole departments everywhere use some or all of the treatment methods. Some experimental programs have even approached this degree of treatment intensity without improved success rates. Because intensive treatment by competent personnel does not of itself guarantee results that differ significantly from those of routine, nonintensive programs, it was assumed that the project must include something more than good intentions, skilled workers, and small caseloads. Therefore, the project has been organized around a typological approach, growing out of a theory of delinquency and providing a method of classification which prescribes effective treatment.

Two important theoretical assumptions underline this approach to treatment and control of delinquents: (1) delinquents are not all alike; and (2) delinquents can be grouped meaningfully into types having clear-cut implications for the kind of treatment required. These assumptions guard against the mistake of administering the same kind of treatment to all or, on the other hand, of attempting to define an infinite variety of treatments to fit the uniqueness of each case.

The typology used in this project includes nine subtypes of delinquents, classified according to interpersonal maturity level and typical mode of interaction with the world.[1] The nine subtypes fall into three larger groupings along a developmental continuum of social maturity,[2] called low, middle, and high maturity delinquents, with each large group calling for grossly different approaches to treatment and control. Treatment methods regarded as appropriate for youths in subtypes of one class would be considered highly inappropriate for those in subtypes of the other two classes.

In the absence of a full delineation of the differential treatment theory upon which the typology is based, the case examples in this article are cited primarily to illustrate the point that delinquents are different and can be classified according to their treatment needs. Theoretical conclusions drawn from only three examples would be overgeneralizations of the nine-type system.

Differential Treatment

The three broad classifications in the project are:

1. **Low-Maturity Cases.** The youth in this classification is extremely immature and dependent. His relationships with others are focused on whether they give to him or deny him. The whole world centers on his needs, which are of the "bottomless pit" variety. He feels no guilt but his existence produces a sense of guilt in others. He behaves impulsively and destructively. When frustrated, he may appear openly hostile or simply resentful. In either case, he appears disorganized, unsocialized, and maladaptive. The community sees him as helpless, hapless, and hopeless, but not necessarily criminalistic. Far from being a dedicated delinquent, he blunders into delinquencies or is used by others.

The early histories of the low-maturity delinquents show them to be victims of neglect and often brutality. Their lives have been filled with fear and devoid of the love and approval which lead to socialization. In addition to irresponsible, hostile, and rejecting parents, they typically have come into contact with a variety of foster parents, sandwiched between detention in a variety of juvenile halls. They feel buffeted about by an arbitrary, unpredictable world.

Treatment goals formulated for this type of delinquent include: reducing the pressure of asocial drives; developing some degree of conformity by strengthening self-controls; reducing the sense of isolation and rejection through a warm, supportive relationship; and protecting the child from being made a scapegoat. An extremely tolerant foster or group home is essential and a large part of the community agent's job is lending support to the foster parents.

The agent's treatment role with the youth is to represent an omnipresent generalized adult (rather than someone insisting on a close relationship) who controls with patience and kindliness. The agent offers warm support in going through daily life experiences with the child. Insight therapy is not appropriate.

Since the low-maturity youth wreaks havoc in school and on a job, the agent spends considerable time interpreting his behavior to others and suggesting control techniques. The agent himself needs much support in having to deal with the frustrations he meets in working with this kind of child.

Randy came to the Youth Authority 15 months ago at age 13 after experiencing failure in the last of his nine foster homes. Previous foster parents and school personnel described him as impulsive, belligerent, lonely, demanding, disruptive, agitating, needling, and bullying. His father deserted the family when Randy was born. His mother left him in the care of the hospital officials who presided at his birth. Subsequently, she gave him up for adoption but this never materialized. She is now in jail on prostitution charges.

The essence of the treatment plan for Randy has been the permanent foster home as a reconstituted family. His community agent placed him with an unusual middle-aged couple who are warm, affectionate, and active. Both foster parents have been accepting and protective toward Randy. Their early demands on him were simple and concrete. Gradually, they have insisted on greater conformity but have continued to have considerable tolerance for his outbursts, withdrawals, and demands. They have given him their interest and attention and have rewarded his attempts at self-responsibility. Apparently able to look past the chaos he creates to the unhappiness he has experienced, they have encouraged him to think of their home as his own and of himself as their son. Although no legal adoption is contemplated, Randy insists on using the foster parents' last name as his own.

The community agent spends some time with Randy every day in the home and in the school, and brings him to the project center twice a week for supplemental tutoring. Three times a week Randy participates with other low-maturity delinquents in an activity group in order to develop some ability to relate to his peers.

To date, project procedures have been successful in preventing serious delinquent acts in the low-maturity group. However, caution in evaluation is appropriate if permanent personality change is the measure of success. True, Randy's most serious offense in the past 15 months has been the theft of a candy bar; and for the first time in his life he has successfully completed a year of school without being expelled. He is better behaved and better able to predict the reactions of others. To some extent he is now aware of what others are trying to do for him, and has achieved some feeling of belongingness. However, time and energy investment from the foster parents and the project have been tremendous, and the effect of removing some of this support remains unknown. There is the strong possibility that Randy will never make more than a marginal adjustment. Yet, lifelong marginality must be preferable to a lifetime of institutionalization.

2. **Middle-Maturity Cases.** The delinquent in this classification operates by applying formulas in order to get what he wants. In contrast to the low-maturity case, he is aware that his own behavior has something to do with whether or not he gets what he wants. He gives the impression of being satisfied with his way of living, denying any disturbing feelings or problems. He does not see why he should change. He regrets being caught, but expects to be smarter the next time.

This type of youth perceives the world on a power dimension. His first questions in any new situation are: "What are the rules and who has the power?" Once he gets this information, he may either react to the power structure in terms of compliance, attempting to appease the power figures by conforming to their expectations; or fight against the power structure, trying in obvious and subtle ways to escape its control. In either case, he usually appears relatively well integrated and at ease except in new situations where the power structure is as yet unclear to him.

This youth usually has a surface facade of intense delinquent loyalties; however, in a crisis he behaves, not on the basis of some inner value system, but rather on the basis of whatever external code of the moment has the support of power behind it. His interpersonal relationships are superficial and short lived. He "knows everyone," but is allergic to close relationships.

In early contacts, the middle-maturity delinquent clings to the myth of the ideal family. Father is "hardworking"; mother is "just what a mother should be"; there are no family problems. A further look at his family, however, reveals a group of emotionally impoverished individuals, living together with little close feeling for each other. They may be unified only in a common distrust of the community and its agencies. The family is typically mother dominated, with the mother wrapped up in her own needs and having little to give the children.

The father role may be vacant or filled by an incapacitated or transient person. The parents' attitudes toward the child are negative and depreciating.

The emotional deprivation in the early life of the middle-maturity delinquent has apparently been less severe than in the life of the low-maturity youth. The rejection of the child by his parents has been more subtle (either less obvious to the child or of the double-bind, or ambivalent, variety). The underlying rejection of each other by the family members, combined with surface verbalizations of acceptance, support, and cohesiveness, has led to one of the most characteristic symptoms of this middle-maturity group—a lack of social perceptiveness in predicting the behavior and responses of others. This delinquent is extremely distrustful of adults and appears to have given up relating to them except on a formula basis. He turns instead to his peers to set the standards for his behavior.

The combination of distrust and relative integration in this type of delinquent makes him impossible to reach with traditional therapy techniques. The usual way of dealing with him is merely to contain him. This, of course, is easy in an institution and difficult in the community.

Project treatment goals for middle-maturity cases include: increasing social perceptiveness so that the child will be better able to predict the behavior and response of others; decreasing the delinquency orientation; and increasing genuine ability to relate to others. The approaches to these goals proceed through three stages: (1) control of overt behavior; (2) obtaining a commitment to nondelinquent attitudes; and (3) training in social perception.

In the first stage, the task of the community agent is to set up a control surveillance system, using school, parents, law enforcement agents, natural peer group, and project treatment peer group. Violation of rules must be immediately followed by intervention. During this stage the agent presents himself as an absolute, arbitrary power, ruthlessly pursuing even trivial violations. But *power* is not enough. The agent must feel, but not openly express, a great deal of warmth and concern for the youth.

In the second stage, the focus becomes an attitude commitment—not *how* you are *behaving* but what kind of *person* you are. The task is one of putting the youth in a corner where he has to make an all-out commitment for or against delinquency. (As one boy said when he finally heard the demand, "You want me to turn in my union card to the hoods and the thieves!") Once the youth has decided that he wants to be like the people in the community who stay out of trouble for reasons other than a simple fear of jail, the third stage of treatment begins. This is a long and difficult training in social perception to help the young person see that everyone else does not think and feel the same way he does. It focuses on helping him to see the differences in people's motives and attitudes, so that he will be able to play more appropriate social roles and be better able to predict the responses of others.

A large part of the treatment in all three stages takes place in guided group interaction sessions with other middle-maturity youths. This group procedure emphasizes current interpersonal interactions and utilizes peer pressures to control behavior and change attitudes.[3] It also provides the youth with a laboratory for learning how to size up others and to respond appropriately.

Middle-maturity delinquents in the project are placed in their own homes, if the parents are able, with encouragement and reeducation, to impose clear external controls. As a minimum, the parents are required to report all violations of the rules to the community agent. If the parents cannot meet even this requirement, the youth is placed for temporary care in a foster home. Meanwhile, the agent may continue to work with his parents, teaching them to set behavioral limits. Formal family group therapy,[4, 5] sometimes used in the project, has not succeeded in changing patterns of communication and interaction in families of middle-maturity delinquents. However, the treatment has sometimes helped the youth to perceive more realistically his parents' inability to be concerned about him.

Dick, age 13, was committed to the Youth Authority for burglary. He had a previous record of numerous burglaries, bike thefts, shoplifting, assault, and failure to obey police officers. A restless boy, he was easily led by peers, insolent toward adults, suspicious, and lacking in remorse, and frequently played the role of buffoon. He is the fifth of 10 children, fathered by at least 6 different men, in a family described as dependent, delinquent, and immoral. An older brother is in prison for robbery and attempted murder.

Dick was placed in his own home because the mother, although preoccupied with her own life, was willing to support the project controls. He was assigned to a peer group for guided group interaction 3 days a week. His agent made firm, immediate demands upon him for good behavior, and asked the school to report misbehavior. Surveillance provided through the mother, the peer group, the school, and the agent made undetected misconduct almost impossible. Dick was held to account for even trivial incidents. Short periods of confinement in the reception center were used when necessary to enforce controls.

Within the first 4 months, Dick began to realize that someone finally cared enough about him to make him behave. While providing rigid controls, the agent gave him open approval for good behavior, and concentrated, through the group, on obtaining and reinforcing a commitment from Dick to nondelinquency as a way of life.

Dick has been in the project for 16 months. During the past year, he has gradually assumed a constructive role in the group and has dispensed with destructive clowning. He apparently enjoys identifying the problems of new group members and turning them away from delinquency. Although he still does not have a strong internalized value system, his social perceptiveness has improved noticeably. Marked changes in Dick's attitude and behavior are obvious to all those who know him.

The project has been very successful in controlling the behavior of its middle-maturity delinquents in the community. With many, the second step of dealing with attitudes and commitments has been reached. In regard to a few, project staff feel confident that internal changes in the direction of greater maturity are beginning to occur.

3. **High-Maturity Cases.** The third large grouping includes the most socially mature cases in the delinquent population. A youth functioning at this level has internalized a set of standards by which he judges his own and others' behavior. He is concerned about status and is strongly influenced by people he admires. He shows some ability to understand reasons for behavior, some ability to think about the future in realistic ways, and some ability to relate to people emotionally and on a long-term basis. The delinquency of most such youths may be regarded as the acting out of an internal conflict, a parental conflict, or a family crisis. The youth is often depressed or guilty about his delinquencies, and feels a need to become a better person.

Some high-maturity delinquents are overtly neurotic and present the same kinds of anxiety symptoms found in the patients of mental hygiene clinics. Others, although neurotic, conceal their symptoms and attempt to avoid anxiety by delinquent action. Still others, basically non-neurotic, have reacted delinquently to emotional crises which have overtaxed their normal coping ability. In addition, a few high-maturity delinquents, labeled in the project as "cultural identifiers," present no personal or family pathology, but have identification models which are at odds with the larger culture. This group represents such a small proportion of project cases that their treatment will not be described here.

Although the proportion of intact, harmonious families among high-maturity delinquents is not higher than among middle-maturity cases, the families of the former generally appear much more concerned about their delinquent child and more adequate in fulfilling parental roles. Family problems found in this group include: criminal, alcoholic, or underachieving fathers; guilt-ridden, seductive, or promiscuous mothers. In most cases, the family problem has led to an identification difficulty for the youth. For example, the child may have identified with a deviant parent or may not have been able to identify with the appropriate parent because the parent was missing or inadequate as a model.

The treatment goals which have been formulated for these high-maturity cases include: identifying the conflict which led to the delinquency and helping the youth toward a solution; helping the youth with his identity problem and strengthening his internalized value system; and creating a situation for maximum use of potentialities.

The treatment approach used differs from approaches used with the delinquents of lower maturity primarily in being internally oriented. The agent's role is to establish quickly a close personal relationship between himself and the youth. Although external controls are sometimes necessary, they are defined as a means of establishing a genuine treatment contract with the youngster. The agent's demands for nondelinquency may range from being firm and forceful to being relatively nondirective, but they are never arbitrary.

Group therapy (rather than guided group interaction) is used as a means of helping the high maturity delinquents to develop insight into their problems and to improve relationships with others. In some cases the treatment group is a peer group; in others the youth and his family. Family group therapy has been most successful in cases in which the delinquency has been a method of drawing attention away from a conflict within the family constellation. With other cases the central problem may be family related, but cannot be resolved through family therapy either because a crucial family member is absent or will not participate.

Paul was committed to the Youth Authority for auto theft shortly after his 16th birthday. He had had eight arrests over a 5-year period, for drunkenness, malicious mischief, and property thefts. In his impoverished neighborhood, he had achieved considerable status through delinquency, but did not seem to enjoy this role. At school he sought status through track competition.

The second of nine children, Paul was usually described as a "normal but quiet" boy. When Paul was 8, his father went to prison for heroin addiction and passing bad checks. An openly promiscuous man, he has been in and out of the home since, but at the time of Paul's arrest was missing. Yet Paul describes his father as a strict, authoritarian man who has a good understanding of teenage boys. Paul's mother is a lethargic woman who gives much affection to her smaller children, but seems to become insensitive to them as they grow older. The home apparently provided enough early strength to allow for some emotional maturation in Paul, but did not provide an adequate identification figure during his adolescent years.

Project staff interpreted Paul's behavior as resulting from his inability to tolerate the anxiety generated in his identity struggle. He escaped from this by throwing himself into athletic endeavors, by developing psychosomatic illnesses, and by delinquent behavior. To prevent further acting out, the agent saw Paul frequently in the beginning of their contact, capitalizing on the boy's perception of him as firm and controlling like the father. At the same time the agent attempted to reduce Paul's anxiety through formal individual therapy sessions. However, the formality created so much further anxiety in Paul that he was unable to discuss his problems. The agent switched to spending time with Paul informally in such activities as just riding around, taking walks, or visiting the zoo. At such times Paul was able to bring up serious problems spontaneously, and when he was placed in a therapy group of his peers, he became one of the better participants.

Paul has now completed a year in the project with no known delinquencies except for one instance of truancy. Although the agent provided external controls initially, his chief aim has been to help Paul increase his own controls and handle anxiety as it develops. He has been supportive to Paul in handling his problems at home and at school. Paul seems to regard the agent as a friend and a counselor in time of need. While differences in background may prevent a true identification, a treatment relationship has been developed which may be sufficient to help Paul complete his identity struggle without further delinquency and self-defeat.

In general, the project is doing rather well with the high-maturity group. However, some of the project's early failures were with high-maturity, neurotic, acting-out delinquents. The early difficulties seem to have been related to the agents' over dependence on psychological, and neglect of external, controls.

Implications of the Program

In the year and a half the project has been operating, 75 boys and girls have entered the community program and 144 comparable youths from the same geographical areas have gone into the Youth Authority's regular programs. The average length of time cases have been carried in the community program is 10 months. Ten boys and one girl have been removed from the project and sent to institutions, because they either committed further law violations or failed to adjust to project demands. A majority of the community-treated delinquents are still under intensive surveillance, so that a comparison with usual parole success rates is not yet appropriate. Program effectiveness can best be measured after more community-treated cases are moved into minimum supervision and a comparable group of institution-treated cases are placed on parole.

Nevertheless, it is already apparent that intensive community treatment, as a substitute for institutionalization, is feasible. At the beginning of the project, law enforcement agencies and other community groups expressed skepticism about the way confirmed delinquents would respond to a program that appeared to be giving them "one more break." By now, the community realizes that tight controls are exerted over cases and serious attempts are made to bring about permanent changes in the youths and their families. As a result, there is increasing acceptance of the project.

If the costs of the Community Treatment Project are compared with a typical field operation, such as probation or parole, they are indeed high. If, however, the costs are compared with the usual institutional program, they are low. The State will be in a position to realize substantial savings in both operative and construction costs if the project is successful.

However, a financial saving is not the most important gain to society if something more is learned about which young lawbreakers must actually be removed from that community in order to control their behavior and which can be controlled and readjusted in an intensive treatment program in the community. If, in addition, a model can be built which prescribes appropriate treatment strategies for defined kinds of delinquents in either setting, an important step will have been taken toward reducing the amount of waste and frustration involved in wholesale, broadside attacks upon the delinquency problem.

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[1] Grant, M. Q.: Interpersonal maturity level classification: juvenile. Community Treatment Project, Sacramento, Calif. 1961.

[2] Sullivan, C. E.; Grant, M. Q.; Grant, J. D.: The development of interpersonal maturity: applications to delinquency. *Psychiatry*, November 1957.

[3] McCorkle, L.; Elias, A.; Bixby, F. L.: The Highfields story: an experimental treatment project for youthful offenders. Henry Holt & Co., New York. 1958.

[4] Bell, J. E.: Family group therapy. U.S. Department of Health, Education, and Welfare, Public Health Service. Public Health Monograph No. 64. 1961.

[5] Ackerman, Nathan W.: Family study and treatment. *Children*, July–August 1961.

An essay review . . .

THE WORLD STANDS OUT

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THE world stands out on either side,[1] and children move out to encounter it in its full dimensions, charting for themselves highly individualized "paths toward mastery." The process by which they do so, always coping with opportunities and challenges, threats and disappointments, is beautifully dealt with by Lois Barclay Murphy and her colleagues at the Menninger Foundation in their new book, "The Widening World of Childhood—Paths Toward Mastery."* It must occasionally seem that nothing short of the spectacular or bizarre has appeal as a topic of investigation in the field of child development. But here is a project which grew out of the investigators' belief that "the ways in which triumph can be achieved both in the large and in the small, the ways in which human beings handle new demands, everyday problems and difficulties, need to be studied in their own right."

This concern with adaptations to routine as well as to dramatic events, made by essentially normal children, is exemplified by the unofficial title of the study on which the book is based—the Coping Project. The report provides a natural history of coping behavior in 32 preschool children; it does not purport to establish the etiology of the various coping patterns observed. Although the authors assert that the study is "nonnormative," the material might be interpreted as illustrative of the range of normal coping patterns to be found in a carefully defined, relatively homogeneous subpopulation.

The methods employed in the study—tests, interviews, play sessions, projective techniques—are not unusual, but all are exploited with maximum creativity and conceptual clarity. For example, instead of being used to measure intellectual level, the intelligence test is used to discover the child's coping techniques in a mildly stressful situation. Similarly, in their observations of social interaction, the investigators avoid the usual concern with the "typical" or "representative" and choose as their laboratory a completely strange situation—a party at the Murphy home—on the assumption that a child is most uniquely himself when faced with newness.

The use of varied methods of study, while adding to the richness of the data, can create problems in interpretation. One is the problem of establishing a hierarchy of confidence should data from different sources be in conflict. In this project, the 30-plus hours of observation on each child are apparently regarded as the ultimate reference source against which data from other channels are appraised. One consequence of this is the emergence of a picture of early childhood characterized by an impressively accurate reality perception rather than by an egocentric, animistic, or fantasy-dominated orientation. Whether under the stress of the strange or difficult or in familiar surroundings, most of the children studied engaged in appropriate reality testing, protected their autonomy by an assortment of effective maneuvers, and exhibited little need to distort reality in the process.

Again to paraphrase Edna St. Vincent Millay, the world of childhood stands out on either side, no wider than the research techniques are wide. Stage a session to elicit aggression and you will have little difficulty getting hostile behavior; arrange conditions differently and you may get a picture of hypertrophied maternal dependency. But arrange your research conditions in such a way as to permit a wide range of behaviors to appear, and you can demonstrate the full breadth of the young child's world.

The theory of personality which underlies the project is a special blend of approximately equal parts of Gardner Murphy and neo-Freudian psychoanalysis, with a dash of Gesell tossed in for extra pungency. The emphasis upon drive patterns is Gardner Murphy; the close alliance of coping techniques and defense mechanisms is psychoanalysis; and the faith in the regulating principles inherent in every personality is Arnold Gesell. The persistence of individual coping patterns in the face of varied patterns of environmental reaction is reminiscent of Gesell's principle of self-regulation of function. Likewise, the interplay between progression and temporary regression as the child moves toward mastery is reminiscent of Gesell's principle of reciprocal interweaving. For example, "'Learning a new skill' or learning to conquer fear usually involved an interaction between resistance to the progressive step and active effort to move ahead."

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*Murphy, Lois Barclay, and Associates: The Widening World of Childhood—Paths Toward Mastery. Basic Books, New York. 1962. 399 pp. $10.

The Approach

In the planned sequence of reports, several of which are now in process, the staff of the Coping Project has chosen to present first the descriptive material about the children rather than data concerned with how the coping styles developed. Thus the present book does not include such intriguing information as the influence of maternal behavior and attitudes in shaping the children's different response patterns. While such a mode of presentation is entirely acceptable, it robs the material of its longitudinal flavor and makes this report essentially cross-sectional. To this reviewer it seems unfortunate to divorce antecedent and even transitory consequents. In their attention to the influence of constitutional attributes—activity, sensory sensitivity, autonomic reactivity—the investigators are, of course, showing some concern for the antecedents of contemporary coping styles; but in the present report such topics receive scant attention. In the authors' own words, "Our first step is the description of what the children themselves did, and their ways of meeting the situations they confronted."

One important consequence of this approach is that it helps to avoid an unnatural fragmentation of the developing child into his motor, cognitive, and affective aspects. The coping process includes coordination of all these aspects of the child's personal resources, as well as the facilitative or inhibitory impact of his interpersonal environment. The infant will utilize them all in maintaining a level of stimulus input which he can handle; similarly, a 3-year-old will cope with a powerful fear through resources drawn from them all. Thus the concept of coping is an integrative one and so should be useful to persons interested in many other aspects of the developmental process.

One encounters the word "coping" as an adjective in the service of a variety of nouns, all with apparently slightly different shades of meaning—coping techniques, coping devices, coping processes, coping strategies, and so forth. Coping devices (such as familiarization and orientation, expending effort and accepting help, employing various defense mechanisms, using escape, avoidance, and negativism) provide the building blocks for the more integrative aspects of maintaining autonomy and gaining mastery. The total coping process is, however, a matter of strategy, of flexible utilization of different devices for dealing with environmental and internal challenges. Say the authors:

> When we say that coping is a synthesizing or integrative concept, and that it deals not only with techniques but with *strategy*, we are emphasizing the role of a function, the way in which a child uses a tendency (to focus on details versus ignoring details, etc.). While coping methods use such resources as alert perception, a reservoir of memories, and so forth, as well as defense mechanisms such as denial and repression, we are also concerned with the nuances, or modulation, or flexibility and adroitness with which these resources are organized and used. We look at the sequelae of specific coping operations and the new coping devices to which they lead.

In spite of such occasional efforts at distinctions in usages, most readers would probably like a more explicit designation of the range of behaviors regarded as coping devices.

A similar problem has to do with the fact that the relationship between a coping technique and a defense mechanism is insufficiently delineated in the authors' exposition. The concept of coping actually subsumes the concept of defense mechanism. For example:

> Coping thus includes not only the more elementary situation-oriented devices but also all of the complex ways in which the child deals with reality as he sees it; defense mechanisms which temporarily deny reality, evade it, distort it, or set barriers against it are involved in coping when direct efforts to handle reality are not possible, or fail.

This hierarchical arrangement makes it difficult to tell when certain patterns of behavior cease being coping techniques and become defense mechanisms. Insofar as they help the child to regulate tension (either by decrease or increase), coping techniques can be said to function as mechanisms of defense, yet perhaps not as "defense mechanisms" as the term is used clinically. Apparently the major distinction has to do with the degree of visibility of successive steps in the defensive process. When the stages are external and obvious, the child is coping; if the intervening step are bypassed, the child is defending.

The authors state that only a minority of the children in the study came through the first 2 to 3 years of life with all of their coping resources intact. Presumably, then, the reduction in variety of coping resources leads to increased utilization of defense mechanisms. Yet, even so, such mechanisms are envisioned as subserving the child's adjustive capacity:

> By the age of 2 to 4 years, all of the children in our study group had already developed a repertoire of . . . defense mechanisms which played their part in the total resources of coping used by each child. . . . Furthermore, the most normal and happy of our group of children drew upon defense mechanisms as part of their total strategy for coping, with considerable flexibility and with changing emphases over the period during which we observed them.
>
> . . . As we follow the development of such efforts to master fears and other stresses on the part of our children, we are struck by the flexibility with which they used defense mechanisms along with overt defensive maneuvers as part of the total coping strategy. This flexibility includes the capacity to use different ones together, when they are needed.

Thus the important distinction appears: the defense mechanism becomes an instrument of pathology, rather than an aspect of the total coping strategy, only when it lulls the child away from its goal of active mastery and into a role of stress containment—i.e., defense. In this context, it would have been helpful if cases which gave evidence of not quite succeeding in this effort had been included in order to permit an analysis of environmental and constitutional factors which might occasionally foster this capitulation to passivity and defense. Occasional straying off "paths toward mastery" can and does occur.

A Structural Flaw

For this reviewer the structure of the book has only one significant flaw—a disproportionate reliance upon narrative in reporting the study's results. For example, take the following tantalizing sentence, unadorned by figures:

> Correlation coefficients suggested that the boy who could be most realistic or objective in regard to real limits was also more cooperative toward authority demands, more able to utilize or demand help, more adequate motorically, more able to express his own needs independently, and more quickly oriented, tended to be slightly older and was relatively free of tension.

Failure to include the correlations,

together with more information about the ways of measuring "cooperative toward authority demands" and "relatively free of tension," is lamentable. A few sample correlations out of a gigantic 640 by 640 matrix are reported in an appendix, but the rationale for their selection is not given. Other reports more concerned with methodology and with the statistical analysis are apparently in preparation. However, in this reviewer's opinion, details of methodology, data analyses, and interpretive comments should remain contiguous conceptually and physically.

One cannot comment on this book without paying tribute to its literary charm. Not only Dr. Murphy, well known for her ability to make scientific materials lively and interesting, but also the entire corps of observers and reporters are in possession of unusual literary talents which deserve special commendation. "The Widening World of Childhood—Paths Toward Mastery" is not likely to have a narrowing group of readers for years to come.

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[1] Millay, Edna St. Vincent: Renascence. Harper & Bros., New York. 1917.

IN THE JOURNALS

Catchup Growth

Children whose growth has been slowed up by illness grow at an accelerated rate after the illness has gone, possibly until the child has caught up with his normal growth curve, according to an article in the May 1963 issue of the *Journal of Pediatrics* by three pediatricians, in Switzerland, England, and Germany. (Catch-Up Growth Following Illness or Starvation," by A. Prader, J. M. Tanner, and G. A. von Harnack.) Through five examples of retarded growth, the article illustrates the velocity of the "catchup" phase—sometimes four times the average rate for the child's chronological age or three times, for his skeletal age—and discusses the mechanism of the catchup phenomenon.

Psychosis and Childbirth

First admissions to all mental hospitals in Massachusetts during 1950 were used as an index of the incidence of mental disease among childbearing and non-childbearing married women in the general population in a study reported in the *New England Journal of Medicine* for May 30, 1963. "Childbearing women" were within 280 days of childbirth—either before or after delivery—while the "non-childbearing women" were not, although they had borne children in the past. ("Rates of Mental Disease Related to Childbearing," by Thomas F. Pugh, M.D., and others.)

Rates of admission for psychotic disorders were higher among the childbearing than the non-childbearing population, but rates for other mental disorders did not differ. Of the psychoses diagnosed in the childbearing women, the manic depressive psychoses were significantly in excess. A deficit of admissions of pregnant women was insufficient to account completely for the excess of women with psychoses admitted during the first 3 months' post partum. The annual added risk of first admission for psychosis due to forces operating in the first 6 weeks of the post partum period was estimated to be 3 to 3.6 per 1,000 women in that stage of the puerperium.

Pastels in Pediatrics

A giggling, laughing, 2-year-old girl, admitted to a hospital pediatric unit by a nurse in a light-blue dress, suddenly ran wailing to her mother when a nurse in a white uniform entered the room. This and parallel observations made in a Florida teaching hospital on the effect of nurses wearing pastel dresses instead of white uniforms when caring for hospitalized children are reported in the May 1963 issue of *Nursing Outlook.* ("Pastels in Pediatrics," by Carol E. Bradshaw and Nancy Chen Cheng.) Reactions among a sample of 100 pediatric patients randomly selected from newborn to 15 years were recorded by two nurses alternating in pastel and white uniforms.

They report a shortened period of adjustment to the hospital environment for the newly admitted child served by a nurse who was in a pastel color uniform, and the most striking contrast in reactions—favorable to colors, unfavorable to white—among children of 9 months to 4 or 5 years. School children showed mixed reactions, some implying that the nurse lost status in the children's eyes, some making such remarks as "I like your pretty dresses . . . children are afraid of white you know." Nurses were three to one in favor of the change.

Decisions for the Child

Referring to those psychologically lost children who keep turning up in child welfare caseloads, Florence Silverblatt, director of social services for the Philadelphia Department of Public Welfare, asks, in an article appearing in the May 1963 issue of *Child Welfare,* whether the broad bases of child welfare—preserving family ties and strengthening family life—are being incorporated in today's social work practice on behalf of children. ("The Child Welfare Agency's Services to Own Parents.")

Calling for a relook at services to parents of children in placement, the author reminds the reader that it is up to the child welfare agency to evaluate parental potential in deciding which families should be helped to keep their children at home and which should be encouraged to place them. She underlines the value of timely dealing with parents when they need the agency's help most critically, "not after years of destructive interaction," and of sensitivity to what parents are saying about their parenthood when they ask for help. The article discusses help to parents toward family reunion, concluding in essence that professional services devoted to the development of emotionally healthy children must be geared to uncovering and nurturing parents' capacities, and also to taking responsibility for "removing the parent" when this is to the child's best interest.

BOOK NOTES

TEEN-AGE TYRANNY. Grace Hechinger and Fred M. Hechinger. William Morrow and Co., Inc., New York. 1963. 259 pp. $4.50.

Based on recent scholarly studies of adolescent social patterns as well as a survey of relevant mass media, this book presents a critical analysis of the values and typical behavior of middle-class American youth.

The authors, an education editor of the New York *Times* and a freelance writer, are particularly concerned with moral and ethical implications of the evolving patterns of adolescent leisure time activities, academic pursuits, and attitudes toward possessions and the privileges of an affluent society.

The chapters include discussions of dating behavior and early marriage, smoking and drinking, advice books, buying habits of adolescents, and the influence of TV. The final chapter presents a series of specific proposals for dealing with some of the problems identified in earlier chapters. The authors state that "the fault is not with youth; the errors are those of adult society." The implications of this viewpoint are explored in the concluding sections of the book.

PREVENTIVE PEDIATRICS: child health and development. Paul A. Harper, M.D. Appleton-Century-Crofts, division of Meredith Publishing Co., New York. 1962. 798 pp. $14.95.

This textbook and reference work on child health supervision was written primarily for "those concerned with understanding and giving advice about growth and behavior," including "private practitioners who care for children and public health workers who are responsible for . . . programs for children and their families." The author is professor of maternal and child health at the School of Hygiene and Public Health; and associate professor of pediatrics at the School of Medicine, Johns Hopkins University.

The first of the book's 12 chapters focuses on "predictable problems of growth and behavior," discussing such subjects as sleep, bladder control, truth and fantasy, fear and anxiety, independence and rebellion, and emotional adjustment to a physical or a mental handicap. It is followed by chapters on patterns of growth and development, selected topics in developmental physiology, nutrition, immunization and the communicable diseases, mental retardation, and other handicaps.

There are also chapters examining a number of aspects of health services which are, or which the author says should be, available to children. Other chapters venture into areas that overlap medicine and education, such as reading disability, and into social problems, such as juvenile delinquency, illegitimacy, and adoption, which the author points out "illustrate beautifully the close relationship of medicine, law, psychology, and social work."

REGIONALIZATION AND RURAL HEALTH CARE. Walter J. McNerney and Donald C. Riedel. The University of Michigan, Ann Arbor. 1962. 209 pp. $5.

An experience in the regionalization of health services in northern Michigan—an effort to pool and coordinate the health services of rural areas, through use of a regional hospital as the core—is scrutinized in this book. Written by specialists in medical and hospital administration, the book opens with a discussion of the need for regional systems of health care, the origins of the regionalization concept in the forties, its slow growth, and its expected byproducts in enhanced efficiency in the use of resources and improved standards of care, especially in rural areas.

The program described in the book was financed largely by the W. K. Kellogg Foundation and was carried out through two 3-year compacts, involving a total of three health centers and two nearby regional hospitals. Seven chapters of the book discuss the operation of the health centers, the extent of regional relationships, community and staff attitudes toward regional affiliation, and the use of the health centers in the three communities, among other subjects. A final chapter summarizes and evaluates the findings and considers their implications.

The authors conclude that in the program studied "regionalization, with its signed agreements, remained, on the whole, a paper achievement." Among the reasons: The programs were sometimes wanting in contractual flexibility, in professional acceptance of community physicians by regional hospital staffs, in involvement of administrative board members, and in public information about regionalization. The authors support their material with charts, tables, and appendices.

SIX CULTURES: studies of child rearing. Beatrice B. Whiting, editor. John Wiley & Sons, New York. 1963. 1,017 pp. $12.50.

Is the Mixtecan child of Mexico, who is constantly carried close to his mother's body, likely to be a more sociable and trusting adult than the Nyansongo child, who is tended less consistently by a preadolescent sibling? The illumination of this and other areas in the pattern of relationships between child rearing and consequent personality was the goal of collaborative research in 1954 by six teams of social scientists from Cornell, Harvard, and Yale Universities—the fruit of which is collected in this book.

Introduced as a reservoir of material relevant to certain "culture-personality" hypothesis which will be tested later on the basis of these and subsequent studies, the volume is organized into six monographs, each probing into the life and ways of a single community in a specific culture—in Kenya, India, Okinawa, Mexico, the Philippines, and the United States—with focus on child rearing practices. Each monograph first reviews the ethnographic background of the community, including social organization, social controls, and education, before presenting observations on child training.

All the monographs reflect roughly the same study design, concentrating on 24 mothers and 24 children aged 3 to 10, particularly in relation to patterns of "succorance" (asking for help), nurturance, self-reliance, obedience, achievement, responsibility, dominance, sociability, and aggression.

These patterns are related to cross-cultural as well as intracultural currents and to age and sex differences that might be universal.

CAUSAL THINKING IN THE CHILD: a genetic and experimental approach. Monique Laurendeau and Adrien Pinard. Preface by Jean Piaget. International Universities Press, New York. 1963. $7.50.

What a child thinks about life, dreams, the movement of clouds, the origins of night, and the floating and sinking of objects was explored by the authors, who are associated with the University of Montreal, for clues to the validity of the stages of mental development in children and their sequence as outlined by Jean Piaget in his theory of causality. Their investigation was carried out in a longitudinal study, part of a project designed to evolve a new scale of intellectual development which they hope will be "better adapted to the prevailing concepts of the nature of intelligence."

The authors review briefly in the first of the book's 13 chapters some of Piaget's forms of causality which the book designates as "precausal" or "primitive." These forms are: phenomenism ("night is the gathering up of many shadows," or "the desire to sleep brings on the night"); finalism ("clouds move in order to carry rain"); artificialism ("men dug rivers and lakes in order to move about"); animism ("clouds know they are moving"); and dynamism ("clouds may choose their own course"). They then analyze and challenge evidence of other investigations into children's mental development which appears to refute Piaget's concept of developmental stages.

Subsequent chapters describe the longitudinal study sample—500 children, ages 4 to 12; study methods; the questionnaires (derived from those developed by Piaget); and the findings. These confirm, according to the authors, the fact that primitive beliefs of causality (generally as described by Piaget) do exist and, in fact, are preponderant among children. Causal or more objective interpretations are progressively substituted for these primitive beliefs, as children pass gradually from the egocentrism of early childhood to adult objectivity.

International Publications

THE NEEDS OF CHILDREN: a survey of the needs of children in the developing countries. Georges Sicault, editor. Published for the United Nations Children's Fund. The Free Press of Glencoe, New York. 1963. 175 pp. $3.95 (cloth); $1.95 (paper).

"Often clad in rags, the majority of children in the less developed countries wander barefooted over disease-infested ground." Through such word-pictures of extreme want, the nature and dimensions of the most pressing needs of the world's children unfold in this handbook for economic and social planners in developing countries. The book is a distillation and blend of material from reports of and to the United Nations Children's Fund (UNICEF).

The first part of the volume, a review by UNICEF, suggests some methods of setting up priorities for breaking the "vicious circle" of poverty, disease, hunger, and ignorance, presenting indicators for measuring the status of health, education, nutrition, and social welfare both in rural areas and areas of "runaway urbanization."

The book's second part is composed of reports to UNICEF on specific problems—health, nutrition, education, social welfare, vocational preparation, and protection from exploitation—from the World Health Organization; the Food and Agriculture Organization; the United Nations Educational, Scientific, and Cultural Organization; the United Nations Bureau of Social Affairs; and the International Labour Organisation.

Part 3 presents condensed reports from a number of countries on their children's primary needs, demonstrating the intensifying effects on deprivation of explosive population growth and "bewildering shifts in economic and social patterns."

DEMOGRAPHIC YEABOOK. 1961, 13th issue. Statistical Office. Department of Economic and Social Affairs, United Nations. 1962. 713 pp. Sales Section, United Nations, New York. $8 paperbound; $10 clothbound.

Under a rotation plan, mortality statistics, previously featured in 1957 and in 1951, are again the topic for intensive treatment in the United Nations Demographic Yearbook, 1961. Official statistics on more than 200 countries and territories are included.

New tables in the area of maternal and child health include: time series of perinatal deaths and ratios, 1952–60; late fetal deaths (duration of pregnancy 20 or more weeks or not stated), 1952–60, with percent illegitimate and sex distribution; fetal death ratios, 1945–60; and death rates specific for age, sex, and marital status.

Trends in total number of infant deaths and in infant mortality rates are shown on an annual basis in the period 1952–61, while 5-year-average annual rates are given for the years 1945–49, 1950–54, and 1955–59, respectively. Annual infant mortality rates, specific for age and sex, are shown for the years 1952–61.

Life tables, referring to the 20-year period 1940–60, including expectation of life and estimated survivors at specified ages, by sex, are also included; as are the usual statistics on marriage, divorce, natality, and world population.

According to these last estimates, world population in 1960 was 2,995 million, as compared with 2,510 million in 1950. The annual rate of increase in the decade was 1.8 percent. Annual rates of increase above this figure were estimated for Africa (2.2 percent), Middle and South America (2.7 percent and 2.3 percent, respectively), Asia (except the South Central Region) and Oceania (2.4 percent).

A cumulative table of contents covers all 13 issues of the Yearbook.

HERE AND THERE

Youth Employment

Late in April the President's Committee on Youth Employment, appointed in November 1962, submitted a report to the President containing 15 recommendations to improve the prospects of young people in the labor market. The Committee, which was under the chairmanship of the Secretary of Labor W. Willard Wirtz, consisted of the Attorney General of the United States; the Secretaries of Commerce, the Interior, Agriculture, and Health, Education, and Welfare; and the Administrator of the Housing and Home Finance Agency; and representatives of industry, labor, State and local government, education, and national social service and parents' organizations. Its recommendations, in brief, were:

1. That Governors and mayors establish continuing committees concerned with youth employment.

2. That employers of all types reexamine their policies to see how they can better employ young people and eliminate discrimination against minority youth.

3. That unions and employers revise contracts and practices which restrict the entry of youth, including minority youth, into beginning jobs.

4. That the Secretary of Labor arrange for a study of apprenticeship programs and future needs.

5. That school systems develop intensive programs to bring out-of-school youth up to standards of employability.

6. That a Federal program for urban and conservation employment and training of youth be enacted.

7. That the Manpower Development and Training Act be amended to increase the allowances for unemployed youth in training and to make them available to out-of-school youth between the ages of 16 and 18.

8. That schools improve teaching methods and curricula for young people going from secondary school to the labor market.

9. That funds be provided to schools in order to improve their programs.

10. That the Secretaries of Labor and Health, Education, and Welfare assist State agencies in promoting special training programs for vocational counselors; and establish a clearinghouse on vocational counseling programs.

11. That vocational education laws be reexamined with a view of strengthening programs and eliminating racial or religious discrimination in the selection of trainees.

12. That skill centers or technical or vocational schools be established in new locations.

13. That child labor restrictions be reexamined to determine whether carefully safeguarded changes may be appropriate to help youth acquire suitable work experience in connection with their schooling.

14. That school attendance laws be extended to all children in the school district including those of migrant farm-workers.

15. That Army pre-induction examinations be given to young men at registration for Selective Service or shortly thereafter to permit early identification and correction of physical or educational defects.

The full report of the Committee is available in a report issued by the Department of Labor entitled "The Challenge of Jobless Youth."

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About 50 representatives of 18 Federal agencies met together May 13–14 for a seminar on the social and economic pressures upon youth. The focus was on non-college young people who are out of school and for whom employment opportunities have dwindled because automation has greatly reduced available jobs at the same time that the war baby bulge in population is entering the labor force. Among the groups' recommendations—in addition to endorsement of the 15 major recommendations of the report of the President's Committee on Youth Employment—are the following:

1. That consideration be given to formulation of a national policy for appropriate training and employment opportunities for all youth; that subsidized jobs be provided to accomplish needed work in areas where labor market demand is not an effective force.

2. That means be developed for intensive remedial education programs for all young men rejected for military service because of functional illiteracy.

3. That broadly based school programs from earliest years throughout formal schooling provide learning experiences for all types of children—of all degrees of readiness.

4. That research be carried out to determine what types of influences are needed in preparation and training, and in actual work experience to help young people succeed on the job.

5. That the States be encouraged to take full advantage of youth programs available with Federal financial participation such as provided under the Public Welfare Amendments of 1962 and the Manpower Development and Training Act.

6. That to achieve total mobilization of presently available resources to prepare youth for employment, citizenship, and parenthood, there be dynamic dissemination of program information among agencies from one level of government to another; rotation of personnel through Federal, State, and local public agencies; and more active cooperation among agencies at all levels.

Child Welfare

Seventeen child welfare research and demonstartion grants totaling $600,484 were awarded by the Children's Bureau in late March, out of 48 grant applications for projects in 10 States and jurisdictions, including the District of Columbia. The approved grants—10 for research and 7 for demonstration projects—went to universities, and voluntary and public agencies and institutions in California (3); the District of Columbia (3); Illinois (2); Massachusetts, Michigan, Missouri, New York (3); Pennsylvania, Texas, and Wisconsin. Three represented funds for the second year of projects previously approved for more than 1 year.

Areas of focus include social group work with parents; relationship between cognitive environment and mental growth in children; the role of social workers in child protective agencies; training of nonprofessional persons for licensing independent day-care and full-time foster homes; the study of unsupervised family day-care arrangements; school-centered rehabilitation for pregnant schoolgirls; casework with unmarried fathers; foster-parent motivation; adoptive parents of older children; group therapy for retarded adolescents; and the conflicting definitions of the roles of positional authorities in prevention and treatment of delinquent behavior.

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To explore ways of coordinating the systems of statistical reporting used by voluntary casework agencies, a small number of representatives from several national groups attended a meeting called by the Family Service Association of America on April 26 in New York City. Participants were from the Child Welfare League of America, the National Traveler's Aid Association, United Community Funds and Councils of America, the Council of Jewish Federations and Welfare Funds, the Outpatient Studies Section of the Biometrics Branch, NIMH, and the U.S. Children's Bureau. The group agreed on the need to set up effective communication among organizations sponsoring reporting systems and, as a preliminary effort, decided to review types of information now being collected by the national organizations represented on individual children, adults, and families. A second meeting, to which representatives of other interested agencies will be invited, is scheduled for the fall of 1963.

Federal Legislation

Funds earmarked for grants to develop day-care services and to train child welfare personnel, authorized by the Public Welfare Amendments of 1962 (see CHILDREN, September–October 1962, p. 199), were included in the supplemental appropriation for maternal and child welfare voted by the 88th Congress in May of this year. Of the $1 million appropriation, $800,000 is earmarked for grants to the States for day-care services provided under their plans for child welfare; and $200,000 for grants to public or other nonprofit institutions of higher learning for special projects for training personnel in the field of child welfare.

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On May 28 President Kennedy signed the new outdoor recreation act (Public Law 88–29). This law authorizes the Secretary of the Interior to maintain a continuing inventory of outdoor recreation needs and resources, to prepare a system of classification of needs, and to formulate a comprehensive nationwide outdoor recreation plan identifying critical problems and recommending solutions. The Secretary is also authorized to provide technical assistance to Federal agencies, States, political subdivisions, and private organizations; to encourage regional cooperation; and to perform research functions directly or by contract or cooperative agreements. Interdepartmental cooperation is provided for, as is cooperation with educational agencies.

Unwed Motherhood

A study of 321 unwed mothers in New York who gave birth for the first time and are keeping their babies is under way in New York City under the auspices of the Community Council of Greater New York. Begun in April 1962, the 3-year study is designed to ascertain the plans of these mothers for taking care of their babies and, through followup interviewing, to learn about the mothers' experiences during the 18 months following delivery. The study is supported in part by a research grant from the Social Security Administration.

In preparation for this study, the Council recently analyzed data drawn from its study of 520 unmarried mothers which was completed in 1960 (see "Two Studies of Unmarried Mothers in New York City," by Hannah M. Adams, CHILDREN, September–October 1961). Selected particularly for analysis were data on the 268 mothers in the sample who had kept their first out-of-wedlock child. A mimeographed report of this analysis has been released under the title, "Some Characteristics of New York City Unmarried Mothers with Special Reference to Those Who Keep the First Out-of-Wedlock Child." This reveals that of the 268 mothers in the earlier study's subsample:

- More than three-quarters were found to have relied for living expenses during pregnancy on their own earnings and savings or on those of the putative father or family members.
- About 20 percent had been dependent to some extent during pregnancy on the city's welfare department; for 11 percent, public assistance was the sole source of help. Four percent had received help from another social agency.
- Forty-four percent of the mothers were under 20 years of age; proportionately fewer of the white women than of any other ethnic group were under 20—30 percent compared with 49 percent of the nonwhite and 36 percent of the Puerto Ricans.
- Sixty-eight percent had had some high school education; and 3 percent, some college training. Seventeen percent had attended grade school only. About 15 percent were still in school, and, of these, two-thirds were under 17 years of age. Among those under 17 years old, 19 percent were not attending school; 85 percent of the 17- to 19-year-olds were out of school.
- More than 90 percent of the group had lived in New York City prior to pregnancy, about 80 percent for at least 3 years. Only 10 percent of the white mothers in this subsample had come to New York during pregnancy (compared with 27 percent of the group of all white unmarried mothers in the total sample, who had come there during pregnancy).
- Forty-four percent had been interviewed by a hospital social worker (compared with 40 percent of the unwed group as a whole). Two out of five had had no social agency contacts at all.

Dependent Children

The great majority of the families in the aid-to-dependent-children program (now aid to families with dependent children) live in "extreme poverty," according to recently released findings of a nationwide study of the ADC program in 1961, sponsored by the American Public Welfare Association. Sixty-eight percent had incomes under $2,000 a year—including the assistance grant—as compared with 7 percent in the population as a whole.

The purpose of the study was to evaluate the effectiveness of the program, to determine the characteristics of its caseload, and to compare the findings with those of a study of ADC made by APWA in 1950 and 1951.

Conducted by the Institute for Research in Social Science of the University of North Carolina and supported by a grant from the Field Foundation, the 1961 study covered every third case closed during the first quarter of 1961 in 42 States and the District of Columbia—jurisdictions having 82 percent of the total ADC caseload. The sample consisted of 5,398 families with 17,715 children.

The investigators conclude that the original aim of ADC, of keeping families together through financial aid, has met with success. They suggest, however, that this goal may not be sufficient, since more than half of the families in the sample had five or more problems in addition to that of financial need. These were problems of mental or physical health, education, behavior, housing, or economics; 17 percent of the families had from 10 to 28 problems in these areas.

On the basis of these and other findings, including evidence that in this "submarginal" group of the population "the slightest jolt" in the economy or their family situations "throws them back," the investigators suggest the advisability of continuing to provide services to some families after the need for financial assistance has passed. They point to the fact that 36 percent of the closed cases were reopened more than once.

Among other findings were:

- A third of the cases in the sample were closed as ineligible although the family was still in financial need.
- For half of the families, ADC payments served as temporary assistance during a crisis—50 percent received assistance 18 months or less. Seventy percent received assistance for less than 5 years.
- Adults in about 60 percent of the families did something or tried to do something to help financially while receiving ADC payments.
- Only 16 percent of the homemakers had skills that could be used in the labor market. Nearly four-fifths had never finished high school and nearly one-half had no more than an eighth-grade education.
- Eighty-one percent of the children on the rolls were born in wedlock (as compared with 85 percent in 1950).
- Nearly 70 percent of youths 18–24 in the sample had not completed high school, in comparison with 38 percent of the general population of this age group; 27 percent had not gone beyond the eighth grade as compared with 13 percent of the same age group in the general population.
- About 95 percent of the children had not been involved in delinquency and criminal offenses since the receipt of ADC.
- Twenty percent of the families lived in critically overcrowded conditions.
- In only 9 percent of the families was child neglect or abuse reported, and in only 4 percent was there a report of the grant not being used primarily for the benefit of the children.

The authors of the report, "An American Dependency Challenge," were M. Elaine Burgess and Daniel O. Price. (Price $3 from the American Public Welfare Association, 1313 East 60th Street, Chicago 37, Ill.)

Illness in Children

Acute illness among children under 15 years of age occurred at a rate of three episodes per child during the year ending June 1961, according to a recently completed analysis by the Children's Bureau of data collected by the National Health Survey on illnesses among children. Respiratory cases accounted for 55 percent of these acute conditions, and injuries, for 11 percent.

The data analyzed were obtained in household interviews of about 125,000 persons per year in about 38,000 households. These were carried out for the bulk of the data during the period from July 1959 through June 1961, but for information on hospitalization, during the 2 years ending July 1960, and on dental care, during the year ending June 1958. The Bureau's analysis of these data will soon be issued in a report entitled "Illness Among Children" by Clara G. Schiffer and Eleanor P. Hunt. It points out among other facts that during the period of the survey:

- On the average, about one chronic condition was reported per four children under 16 years of age.
- Children under 15 (comprising 31 percent of the total population) comprised 38 percent of all persons injured during the 2 years ending June 1961. Injuries occurred at the rate of 30 per 100 children under 15. Thirty-one percent of the injuries to children under 17 were from falls; 52 percent of all accidents affecting children took place about the home. Acute illnesses occurred with greatest frequency among urban children (314 illnesses per 100 children) than among either rural nonfarm children (296 per 100) or rural farm children (225 per 100).
- Hospital discharges among children averaged annually 63 per 1,000 children under 15, for the period July 1958–June 1960. The rate among nonwhite children was 41 per 1,000 and 66 per 1,000 for white children, but average hospital stays were 10 days among nonwhite children compared with less than 6 days among white children. Nine out of ten hospitalized children went to general hospitals. Children under 15 were 16.6 percent of the population of these hospitals. More than 4 out of 10 children in hospitals were there because of respiratory conditions, including conditions related to the tonsils and adenoids. Over half of those under 15 years of age in hospitals had surgery, and 45 percent of these had tonsillectomies or adenoidectomies.
- Among school age children, the most common physical defect was dental caries. More than half of the Nation's children had never been to a dentist. This was true of 28 percent of children 5 through 14 years of age.

Mental Retardation

A 3-day institute on nutrition service in mental retardation programs—in which public health nutritionists, pediatric dietitians, public health nurses, and others explored their roles and functions in programs for mentally retarded children—was held in Cincinnati, Ohio, in the late spring of 1963. Sponsors were the Children's Bureau; the Maternal and Child Health Division of the Ohio Department of Health; the Ohio Department of Mental Hygiene and Corrections; and two Cincinnati organizations, the Hamilton County Diagnostic Clinic and the Children's Hospital Research Foundation.

The more than 100 participants—from 35 States, the District of Columbia, and Puerto Rico—were persons involved in services for mentally retarded children, either through public or private clinical programs or followup care in the home and community. Speakers, consultants, and resource people represented the fields of pediatrics, medical research, physical medicine, dentistry, physical and occupational therapy, medical social work, psychology, speech and hearing, and public health nursing.

The conferees discussed ways of strengthening and extending the nutrition component in the care of retarded children, highlighting the mutual dependence of the various health disciplines in these efforts. The importance of strengthening the preparation of nutritionists and dietitians for work in this field was also stressed, with suggestions made for preservice training via dietetic internships, graduate nutrition programs, and planned on-the-job training. It was also pointed out that the largely unknown factors concerning the dietary aspects of metabolic errors and the nutritional needs of the mentally retarded child can be illuminated only by further research in partnership with medicine and biochemistry.

For Migrant Children

By mid-May plans were under way in a number of States for summer day-care services to children of agricultural migrants, but plans in other States were too amorphous to report. Among the States where such planning was taking definite shape were:

- *Iowa*, where in Muscatine County a day-care center will again be operated by the Muscatine Migrant Council, with financial support from local Catholic and Protestant religious organizations and a large canning company which owns farms in the area. Licensed by the State department of social welfare, the center will have six teachers. Food, some prepared from agricultural surplus commodities, will be served by women's church groups. The State department of health is providing a nurse to serve the migrant families through the center.
- *Kansas*, where there will be day-care centers (full day) in Finney and Kearney Counties and 2- to 3-hour play groups in Wichita and Grant Counties. The center in Finney County, at Holcomb, is being financed through the State board of health from a special $5,000 appropriation made by the State legislature. It will be operated by the Kansas State University, with help from the Migrant Ministry of the State Council of Churches. The center in Kearney County is community financed, with local church groups and the Council of Churches' Migrant Ministry playing major roles. Children in all the centers will be given physical examinations and immunizations by State and local health department personnel and referred to appropriate resources for any needed medical or dental care.
- *Maryland*, where the State welfare department will continue the purchase of day care in a center operated by the Council of Churches at Somerset. This serves an average of 30 migrant children a day and is open from 6:30 a.m. until 9:30 p.m. The parents pay 25 cents a day for the first child and 15 cents for each additional child.
- *North Carolina*, where there will be six day-care centers for migrant children as compared with two last year (see "A Child Welfare Worker in a Program for Migrants," CHILDREN, May–June 1963). The six centers will be operated by the State Council of Churches, with care being purchased by the State board of public welfare, and fees up to 25 cents a day collected from parents when they can afford it. The board also had plans for the purchase of family day care for infants. Four counties were planning to extend homemaker services to migrant farm families, including the two which did so last year.
- *Pennsylvania*, where 12 day-care centers—including 2 new this year—will care for an estimated 400 migrant children in 9 areas of the State, the operation of all but one by the Pennsylvania State University and all financed by State department of public welfare.
- *Texas*, where the State department of public welfare was providing two communities with assistance in planning community-financed day-care centers for migrant children. Other communities had surveys of day-care needs in progress in which the day-care needs of migrant children were reported as being taken into consideration.
- *Virginia*, which will have two centers for migrant children—in Cheritan and Mappsville—operated by the Council of Churches, from which the State welfare department plans to purchase care for a maximum of 50 migrant children a day.

For Health

A 1-day workshop designed to stimulate hospitals to develop play activities for children in their pediatric units was held recently in Trenton, N.J., by the Maternal and Child Health Program of the New Jersey Department of Health. Attended by 36 nurses and volunteers serving in pediatric units of hospitals within New Jersey's Central Health District, the workshop was an outgrowth of a conference on volunteer services in pediatric units held last year by the State health department in conjunction with the Middle Atlantic Hospital Assembly, during which the place of play in a total care program for the hospitalized child had been stressed.

Divided into five groups, the participants in the workshop discussed such subjects as the use of toys, inexpensive play activity, the consideration of age level and physical limitations when planning for the child, and the relationship between nurses and volunteers in carrying out play programs. A summary of the groups' deliberations was used as a springboard for a final plenary discussion, led by a panel composed of a nurse, a hospital administrator, a director of volunteers, and a pediatrician. Kits of materials—including a specially prepared booklet, "Play For Hospitalized Children"—were distributed and a variety of inexpensive play materials displayed among the exhibits. Also, consultation was offered to participants interested in starting or expanding such programs.

. . .

A warning to home gardeners to keep flower bulbs and seeds away from small children, who may want to taste-test them, was issued this spring by the Accident Prevention Division of the Public Health Service. According to the Service, parts of many plants and shrubs are poisonous, and in many cases bulbs and seeds were treated before purchase with chemicals to inhibit deterioration and insect damage. The Poison Control Network affiliated with the Public Health Service received 725 emergency reports of bulb, seed, or plant ingestions by children under 5 in 1961. This was 2.3 percent of all inquiries received by the poison control centers that year; the same percentage of total reports held for the year before when there were 653 calls.

. . .

Self-studies for improving health services are expected to be undertaken by some 20 communities in cooperation with the National Commission on Community Health Services, a non-profit agency established a year ago to conduct a 4-year study of community health needs and services. (See CHILDREN, September–October 1962, p. 205.) Criteria for selecting the communities were drafted at the commission's first annual meeting held in New York at the close of January. They included factors related to geographic distribution, population size, community endorsement, and the availability of personnel and financial resources.

Communities already accepted by June 1 were Knoxville, Tenn., and Cape May, N.J.

At the same meeting, the commission approved plans for seven task forces, charging one of them with identifying, analyzing, and demonstrating principles and methods which facilitate effective action by communities to meet their specific health needs. The other task forces are to focus on environmental health, organization, manpower financing, personal health services, and health service institutions.

Miscellaneous

By March of this year, the Intercollegiate Volunteer Council, a new organization of student volunteers in the Washington, D.C., area, had supplied about 500 volunteers to agencies in the community for activities directed to the children of deprived families. Organized in January of this year, with the cooperation of 10 universities and colleges in the area, the Council provides volunteers to settlement houses, the Boy Scouts, the Boys Clubs, the Metropolitan Athletic Association, church-affiliated groups, and 2 institutions for children operated by the District government. Among other activities, volunteers tutor, supervise athletics, teach skills, and lead hobby groups. With headquarters on the campus of American University, the group recruits through student committees in each of the participating schools.

. . .

The Interdepartmental Committee on Children and Youth has formed a subcommittee on parent and family life education to work toward implementation of the recommendations of the 1960 White House Conference on Children and Youth pertaining to parent and family life education. Federal agencies represented on the subcommittee are: the Office of Education, the Public Health Service, including the National Institute of Mental Health, the Children's Bureau, the Bureau of Family Services, the Vocational Rehabilitation Administration, Department of Health, Education, and Welfare; the Federal Extension Service, Department of Agriculture; the Housing and Home Finance Agency; and the Selective Service System. Edward Pope, specialist in child development and family relations of the Federal Extension Service, is the chairman. Catherine Chilman, parent education specialist for the Children's Bureau, is the executive secretary.

Guides and Reports

SOCIAL AND RECREATIONAL PATTERNS OF ORTHOPEDICALLY HANDICAPPED CHILDREN. A study and report. Arthur Schwartz. Associated YM-YWHAs of Greater New York, 33 West 60th Street, New York 32. 1962. 48 pp. $1.25.

Describes a study focused on a New York community center and the surrounding area to determine the socio-recreational needs of physically handicapped children and their parents in the neighborhood as an aid in establishing a service program.

BODY BUILD AND BEHAVIOR IN YOUNG CHILDREN: I. Body Build and Nursery School Teachers' Ratings. Richard N. Walker. Monographs of the Society for Research in Child Development. Vol. 27, No. 3, Serial No. 84. Child Development Publications, Purdue University, Lafayette, Ind. 1962. 94 pp. $2.75.

This report presents evidence that certain associations exist between the physiques of preschool children and particular behavior traits; and that these associations arise from direct and indirect learning experiences as well as from primary bodily states, including strength, energy, and sensory thresholds.

HELPING THE FAMILY IN URBAN SOCIETY. Edited by Fred Delli-Quadri. Columbia University Press, 2960 Broadway, New York 27. 1963. 184 pp. $4.

Contains 14 papers from the 1962 National Conference of Social Work reflecting its theme, "Social Goals of a Free Society," and focusing on the contemporary social factors that affect family life in an urban society and the services designed for strengthening it.

PROCEEDINGS: INSTITUTE ON ADMINISTRATION IN CRIPPLED CHILDREN SERVICES. Berkeley, Calif., June 24–29, 1962. 126 pp. Copies are available without charge from the California Department of Public Health, Berkeley 4; limited quantity available.

The 19 papers in this report of an institute sponsored by the School of Public Health, University of California, the Crippled Children Services of the California State Department of Public Health, and the Children's Bureau cover various aspects of administrative problems of crippled children programs, methods of selling these programs to the public and the legislature, standard setting, case management, personnel development, and program evaluation.

For Parents

CHILDHOOD AND ADOLESCENCE. J. A. Hadfield. Penguin Books, Baltimore, Md. 1962. 286 pp. $1.25.

HOW TO GIVE YOUR CHILD A GOOD START IN LIFE. Leland E. Glover. Collier Books, New York. 1962. 223 pp. 95 cents. (Paperback)

HOW TO HELP YOUR TEENAGER GROW UP. Leland E. Glover. Collier Books, New York. 1962. 254 pp. 95 cents. (Paperback)

DIAGNOSIS: EPILEPSY; a guide for parents. Jacqueline T. Leonhard. Parents Committee on Epilepsy, Family Health Association, Cleveland, Ohio. 1962. 39 pp. 50 cents.

FAMILY CASEWORK DIAGNOSIS—AN INTERPRETATION

ALICE VOILAND BUELL

Consultant Associate, Community Research Associates, New York

IN limited space it is impossible to deal adequately with the numerous questions which Dr. Nathan W. Ackerman raised or implied in his critique of our study, "Family Casework Diagnosis,"[1] which appeared in the previous issue of CHILDREN. (May–June 1963, pp. 116–118.) Each merits a full discussion. On many we are reasonably sure there could be a meeting of minds. Here, we will comment briefly on three which seem to us of most importance.

The first is key to much of Dr. Ackerman's critique. As he says of his own comments, ". . . the present review must contain an element of special bias, since it is written by a psychiatrist and is influenced by his special interest in the psychodynamics and psychotherapy of the family group." He also describes our own special interest: "The aim of the study which this book reports was to find ways to improve diagnosis of the phenomenon of family disorder by designing a system of classification which would enable social caseworkers to deal more effectively with families burdened by dependency, ill health, and maladjustment." This is a fair statement except that the book was not directed exclusively to caseworkers focusing on these problems; nor were the families in the study selected through problem criteria.

The two interests, psychiatry and social casework, although complementary, are not identical. We do not question the importance of Dr. Ackerman's focus upon the more complex aspects of psychic phenomena of interaction expressed through the emotional conflicts among members of the family group. Nor do we question its purpose: psychotherapy of the family group.

Our work was not conducted for this purpose. It was to create a conceptual base from which to forge better working tools for family diagnosis that can be used by all social caseworkers employed in public and private social agencies. In interpreting our case materials, we drew heavily upon present knowledge about human development available from psychiatry, psychoanalysis, and other sciences. We did not aim to add new knowledge about psychic phenomena of interpersonal interaction in the family setting.

The second point is a natural corollary of the first. Dr. Ackerman mentions that the book contains ". . . a framework for family diagnosis suitable for analysis of psychosocial data about families." Our purpose would have been more accurately reflected if the sentence had read "suitable for analysis of psychosocial data about family social functioning by social caseworkers."

Social functioning is the peculiar province of the social caseworker. The framework provides a way to organize and analyze more systematically data in four defined functional areas—financial function, marital function, child rearing (encompassing both parental function and child development), and adult adjustment. Largely on the foundation of this framework, Community Research Associates has built specific operating instruments now being used in agency practice. These provide for the collection, recording, and analysis of objective facts from various sources, as well as of clinical evidence obtained from direct contact with the families. Prognostic judgments are a part of this.

In the study, the development of this framework and the identification of the four family types proceeded simultaneously. In practice, however, classification by family type derives from the diagnostic process encompassed by this framework.

Admittedly these guiding principles do not stipulate methods of diagnosis. There is no reason why holding office interviews with the entire family, as Dr. Ackerman does, could not be one, provided several things eventually are demonstrated about this method: (1) that it adds substantial knowledge about the totality of family functioning that can be secured in no other way; (2) that it can be used effectively by social caseworkers without continued psychiatric supervision and interpretation; and (3) that it can be used appropriately in agencies whose caseloads are not highly selective and protected.

Systematic procedures, based largely on the concepts and formulations presented in our book, are now being used in public welfare departments in five States and in several voluntary casework agencies. Those using this approach assert that they enable the caseworker to achieve a more complete diagnostic picture of total family functioning than previously used methods of social casework practice.

Epidemiological data from CRA's experimental county projects showed that of all the families served by all community-supported welfare and health agencies, 30 out of every 1,000 showed evidence of some form of "disordered behavior." No one knows with any accuracy what proportion of these families could best be dealt with by some form of psychiatric treatment or some form of social casework. Except for the more serious forms of mental illness, no clear guidelines exist for making these distinctions. Certain epidemiological data gathered by CRA suggests, however, that psychiatric service would be the more effective method in from 10 to 15 percent of the total number of families with disordered behavior. Practically no community now has available the psychiatric resources required to handle even this volume of service.

We quite agree with Dr. Ackerman about the necessity for a concept of normal family social functioning "out of which we may derive levels and degrees of deviance. . . ." We cannot agree, however, that: "The study makes reference to an idealized normal family, but the model of such a family is not presented." The book contains an entire chapter on the "healthy family," which precedes the chapters discussing family dysfunctioning.

We also agree with Dr. Ackerman's affirmation of the "sheer scientific enormity of the problem of family dynamics." We might add, however, that this in no way justifies social agencies' abdication of responsibility for utilizing best current knowledge in a positive effort to resolve, insofar as possible, the problems of social dysfunction which their families present.

---

[1] Voiland, Alice L., and Associates: Family casework diagnosis. Columbia University Press, New York. 1962.

Films on Child Life

Films listed here have been reviewed by staff members of the Children's Bureau. The listing does not constitute endorsement of a film, but indicates that its contents have merit. Charges for rental or purchase, not given because they change, may be obtained from distributors.

ONE AND TWO AND THREE. 15 minutes; sound; color; purchase.

This educational film, consisting of two 7½ minute units on one print, dramatizes at a slow, repetitive pace a method of teaching the meaning of the number concepts 1, 2, and 3 to mentally retarded children and provides some instruction on farm life.

Audience: Administrative personnel of services for mentally retarded children, teachers of such children, and mentally retarded children.

Produced by: Sy Wexler Film Productions, Los Angeles, Calif., with the directors of Special Services and the Instructional Materials Center and the teachers of the Park School of Severely Retarded Children, Evanston, Ill.

Distributed by: Henk Newenhouse, Inc., 614 Davis Street, Evanston, Ill.

MEDICAL CARE FOR ADOLESCENTS. 29 minutes; sound; color; loan.

Shows the importance of good medical and hospital care for adolescents and of their having physicians in whom they can confide, who can recognize and handle the emotional as well as physical needs of teenagers.

Audience: Psychiatrists and other physicians, parents, counselors, community groups, and hospital boards.

Produced by: Southern Medical Association, in cooperation with the Merck Sharp & Dohme Film Library.

Distributed by: Southern Medical Association, 2601 Highland Avenue, Birmingham 5, Ala.; and Merck Sharp & Dohme Film Library, care of Ralph Lopatin Productions, 1617 Pennsylvania Boulevard, Philadelphia 3, Pa.

YOUTH AND THE LAW. 36 minutes; sound; black and white; borrow, rent, or purchase.

Portrays a variety of situations in which the police have contact with children and adolescents in trouble; demonstrates techniques for dealing with them; points up the importance of teamwork between a community's mental health and law enforcement personnel; and illustrates the concept of guidance rather than punishment as the basis of juvenile law.

Audience: Administrative police personnel and police-training personnel, citizen groups, professional personnel who work with young people, mental health professionals, and community organizers.

Produced by: Affiliated Films.

Distributed by: International Film Bureau, Inc., 332 South Michigan Avenue, Chicago 4, Ill. (to purchase); local State mental health authority or film library, to borrow or rent.

WHEN I'M OLD ENOUGH . . . GOODBYE! 28 minutes; sound; black and white; free loan.

U.S. Department of Labor's film, which was placed second in the "Government Films for General Information" category at the San Francisco International Film Festival, deals with school dropouts and portrays the dilemma and subsequent problems of the youth who decides to quit school; shows his motives for the decision; and illustrates possible solutions for parents, teachers, and others.

Audience: All in-school youth and potential dropouts; parents, school guidance counselors, and school curriculum planners; youth-service organizations; youth organizations; and the general public.

Produced by: Louis de Rochemont Associates.

Distributed by: State Employment Services acting in cooperation with the U.S. Employment Service of the Bureau of Employment Security, U.S. Department of Labor.

SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

Publications for which prices are quoted are for sale by the Superintendent of Documents, U.S. Government Printing Office, Washington 25, D.C. Orders should be accompanied by payment. Twenty-five percent discount on quantities of 100 or more.

A CREATIVE LIFE FOR YOUR CHILDREN. Margaret Mead. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Headliner Series No. 1. 1962. 41 pp. 35 cents.

Directed to today's parents and to everyone associated with children, this illustrated booklet written by anthropologist Margaret Mead emphasizes the importance of treating the child as a separate, complete, responsible person from infancy through adolescence. It points out that each phase of mental and physical development in a child's life affords parents, communities, and the Nation another chance to find ways of providing opportunities to inspire the child to use his growing energies and strengths toward creative, constructive adulthood.

SOCIAL SERVICES FOR UNMARRIED MOTHERS AND THEIR CHILDREN PROVIDED THROUGH PUBLIC AND VOLUNTARY CHILD WELFARE AGENCIES. Hannah M. Adams. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. Child Welfare Report No. 12. 1962. 44 pp. Single copies free on request.

This report presents information received from 52 State departments of public welfare and other sources concerning the types and volume of social services for unmarried mothers provided by public and voluntary child welfare agencies. Analyzing the needs for additional services as reported from the States, it concludes that more public service is needed in at least two-thirds of the States.

POLICE WORK WITH CHILDREN: perspectives and principles. Richard A. Myren and Lynn D. Swanson. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 399. 1962. 106 pp. 35 cents.

The result of Children's Bureau collaboration in research and in consultation with several national organizations of law enforcement officials and over 150 specialists in the field of corrections and the behavioral sciences, this publication discusses some of the legal complications involved in law enforcement as it relates to children and youth in conflict with the law and the resultant problems facing police officers and administrators of correctional agencies. It also discusses and recommends principles and practices in police procedures, gleaned from legislation and judicial decisions in various jurisdictions throughout the Nation.

RESEARCH RELATING TO CHILDREN, Bulletin no. 16 (July 1962–January 1963). Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. 1963. 146 pp. $1.

As in previous issues, this bulletin includes only those projects reported to the Clearinghouse for Research in Child Life during the designated period. The studies described are on research projects in progress or very recently completed and cover such areas as: growth and development; personality and adjustment; educational process; exceptional children; the child in the family; social, economic and cultural influences; health services and surveys; and social services and surveys.

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Problems of Rural Youth

Day Care for Deprived Children

Identifying Abused Children

Citizen's Role in Welfare

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◀

HELPING OUT ON THE FARM, once a realistic vocational preparation for most rural youth. Today with opportunities for farm careers dwindling as agriculture becomes increasingly mechanized and industrialized, most rural youth must turn cityward for hope of employment. Problems of preparing young people in rural areas for life in an urban society are discussed in the article which begins this issue.

Dr. Lee Burchinal (left), as of mid-September, is acting chief of the research grants branch of the Research Division in the Office of the U.S. Commissioner of Welfare, Department of Health, Education, and Welfare. Previous to his going to the U.S. Department of Agriculture a year ago, he was professor of sociology at Iowa State University. Dr. James Cowhig, also a sociologist, was at one time with the Michigan Department of Mental Health.

In addition to her position at the natural history museum, Margaret Mead holds a professorship at Columbia University and visiting professorships at the University of Cincinnati and at the Menninger Foundation, Topeka. Her research in primitive societies has resulted in numerous publications, beginning in 1928 with the still best-seller, "Growing Up in Samoa."

A graduate of the New York School of Social Work, Eleanor Hosley has been with the Day Nursery Association of Cleveland since 1937, first as head of its social service department and since 1947 as executive director. She is also senior instructor in child development at the school of medicine at Western Reserve University.

A graduate of the Smith College School of Social Work, Elizabeth Elmer teaches in the medical school of the University of Pittsburgh in addition to directing the 50 families project she describes in her article. Before going to Pittsburgh in 1954, she did psychiatric casework with children at the Strong Memorial Hospital in Rochester, N.Y.

In addition to his professional duties, Dr. Alfred Kahn carries responsibilities as consultant to the Citizens' Committee for Children of New York City, Inc., and as chairman of the commission on social work practice of the National Association of Social Workers. His recently published book on social planning is reviewed on page 196.

Besides her work at UCLA, Florence Goldy (right) has done social work research in the Home Care Departments of the Montefiore Hospital in Pittsburgh and the City of Hope Medical Center at Durate, Calif. Alfred Katz (left) has his Ph. D. in social welfare and teaches at the public health and social work schools of UCLA.

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RURAL YOUTH IN AN URBAN SOCIETY

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THE 13 million young people between 15 and 19 years of age in the United States today are members of a highly urbanized society which has seen rapid and far reaching technological and social changes. They will enter a labor market characterized by rapid automation and shifts in employment from production to service jobs. Most of the available jobs will require comparatively high levels of intellectual ability, formal training, and a capacity to work with others.

One-third of these 13 million young people are now living in rural areas—on farms, elsewhere in the open country, or in villages of less than 2,500 people. How will they fare in this increasingly urbanized society?

Any realistic discussion of rural youth today must begin by recognizing that many young persons now living in rural areas will pursue their adult careers in urban communities. Even now the rural labor market has more people than jobs. Employment in farming is declining and will continue to decline. Expected increases in jobs available in rural areas will not provide adequate employment for the rural labor force in the foreseeable future. Thus many rural young persons must follow the traditional path of migration to the city in search of work. But such migration now occurs under a new condition: urban areas no longer need nor can they absorb masses of unskilled workers.

Conditions are also changing in rural areas. Successful farming today requires higher levels of technical and managerial competence than in the past. And the kinds of jobs held by rural-nonfarm residents are becoming more like those of city persons. Thus, whether rural youth seek rural or urban employment, they face similar circumstances—the need for more education or specialized training than rural youth of a generation ago, and the prospect of harder competition for jobs.

How well are rural youth prepared to meet these conditions? There is reason to believe that in comparison with urban youth, rural youth are at a distinct disadvantage.

Advances in transportation and communication and a long period of general economic prosperity in the country as a whole have reduced, but have not eliminated, rural-urban differences. Some of the differences, especially in education, seriously impede rural youth from fully realizing their employment potential. Moreover, reliance on older rural work values such as physical strength, informal training, and being one's own boss may handicap rural youth in preparing for work in a society dominated by large-scale organizations with highly specialized work roles.

Almost half (6 million) of the rural youth 15 to 19 years old in the United States in 1960 were living in the South. One million of them were Negro. This means that the problems of rural youth have a regional and a racial aspect.

To illustrate some of the problems of rural youth, we have drawn upon a wide range of research data. Some of these data supply only a limited basis for generalization, either because they were drawn only from one specific geographical area or because the treatment of certain important variables, such as

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The views expressed are those of the authors and not necessarily those of the United States Department of Agriculture.

socioeconomic status, differed in the various studies from which they were derived. In spite of these limitations, we believe the consistency of the data allows some generalizations that throw light on important problems facing young people in rural areas.

Backgrounds of Rural Youth

Comparisons of the backgrounds of rural and urban youth indicate that on the whole:

- *Parents of rural youth have lower levels of education.*

National data are not available on the educational levels of parents specifically, but years of education are reported for all persons 25 years of age or older. What is true of these adults probably is also true for the parents of rural and urban youth. In 1960, the median of years of education achieved by white urban males 25 years of age or older was 11.3, as compared with 9.4 for white rural-nonfarm males and 8.7 for white farm males. Educational levels for Negro males were considerably lower: urban, 8.5; rural-nonfarm, 5.8; and farm, 4.8 years of education. Similar differences existed among women.

- *Rural families have lower incomes.*

In 1959, the median money income for all white urban families with two children under 18 was $6,678. Medians of income for white rural-nonfarm and white farm families of this composition were $5,549 and $3,863, respectively. In marked contrast, the medians for Negro families were: urban, $4,469; rural-nonfarm, $2,645; and farm, $1,323. Thus Negro farm families average only one-third as much income as white farm families.

Families with incomes below $2,000 are often referred to as low-income families. On this basis, low incomes are more prevalent among rural than urban families, and is especially acute among Negro farm families. Less than 2 percent of the white urban families and only 5 percent of the white rural-nonfarm families, but 20 percent of the white farm families had incomes under $2,000. Almost 10 percent of the urban Negro families had an annual income of less than $2,000, as did 36 percent of the rural-nonfarm Negro families, and nearly 70 percent of the Negro farm families.

- *Higher status and white-collar jobs are underrepresented among rural workers.*

Differences in the industrial base of rural and urban communities are reflected in differences in occupational distributions. Most obvious, of course, are the higher proportions of rural men primarily employed in farm occupations (26 percent compared with 1 percent of urban men) and the lower proportions of rural men in white-collar jobs (22 percent compared with 40 percent of urban men). Even so, a smaller proportion of rural men were primarily employed as farm operators (18 percent) than as white-collar workers. However, many rural men primarily employed in other occupations are part-time farm operators or farm laborers and are dependent on agriculture.

Differences between the percentages of rural and urban men employed in blue-collar jobs (craftsmen, foremen, operatives, and kindred workers) or as nonfarm laborers are minor. The occupational distribution of the rural-nonfarm labor force closely resembles that of the urban labor force, but the proportion of "white-collar" workers in the rural-nonfarm category is below that of the urban labor force.

The educational and income disadvantages of rural families suggest social, cultural, and material disadvantages for rural youth. Other data support this inference. For instance, national polls of rural and urban youth indicate that rural parents and youth read less, make less use of libraries, and have fewer magazines or books at home.[1] Moreover, smaller proportions of rural than urban youth obtain preventive medical care or are covered by health insurance programs.[2]

- *The quality of rural education still lags behind.*

While there are many excellent rural school systems, national data still point to a lag in rural education. The Department of Rural Education of the National Education Association, in comparing urban school systems with school systems that primarily serve rural children,[3] found that the teachers in rural schools have less education, receive lower salaries, are not so often members of professional educational organizations, and have more complicated teaching responsibilities—about twice as large a proportion of rural as urban teachers teach more than one grade and teach more than one subject. Furthermore, current expenses, instructional costs, and current value of school property—on the basis of per pupil in average daily attendance—are much lower in rural than in urban school systems. Rural averages are lowered considerably by figures for southern rural schools.

However, there are some indications that rural educational systems are attempting to catch up. New capital expenditures for rural districts (based on average daily pupil attendance) have been exceeding similar expenditures that have been incurred in urban school districts.

Educational Attainments and Aspirations

What effects do differences in family and educational backgrounds have on rural youth? Data on three sets of job-related characteristics are used to shed light on this question: (1) the educational attainment and aspirations of youth; (2) their occupational perspectives; and (3) their social-psychological characteristics, including personality traits, attitudes, and values.

- ***Rural-urban differences in school enrollment are slight through high school.***

In 1960, about 75 percent of all urban youth and 73 percent of all rural youth 14 to 19 years old were enrolled in school. School enrollment among young people between the ages of 14 and 17 living in farm and in rural-nonfarm areas and in urban areas also varied only slightly. Among 18-year-olds, 53 percent of urban residents and 46 percent of rural residents were enrolled.

High school graduation has become a *rite de passage* for most youth, rural and urban alike—despite the socioeconomic differences among them. However, some studies have shown important differences in attitudes toward education. In several polls, greater proportions of rural than urban students expressed the opinion that their teachers were paid adequately or were overpaid. In contrast, greater proportions of urban than rural students said they thought their teachers were underpaid.[4] Thus urban youth seem more fully to appreciate the services rendered by their teachers.

In another poll, rural students expressed less interest than urban students in six areas of study: mathematics, foreign languages, science, English, history, and the social sciences. Only in biology did rural students show greater interest than urban students in an academic discipline. On the other hand, rural students expressed the greater interest in shopwork, vocational training, driving, and home economics—subjects directly related to vocations.[1]

Proportionately more rural than urban students said they felt their school curriculum was restrictive and that they wanted additional courses, particularly vocational training, not now offered at their schools. Rural students also more often disliked their courses and had unfavorable views toward school in general.[5] Only 36 percent of the rural students, as against 51 percent of the urban, said they thought their schools helped them sufficiently to discover their vocational abilities.[6]

Developing a skill with tools, as is this rural boy in a 4-H Club program, may have vocational and avocational overtones for nonfarm or city boys as well as those planning to farm.

- ***Rural youth are less likely to continue education beyond high school.***

According to a number of national surveys and State and local studies, smaller proportions of rural than urban youth plan to continue their education beyond high school or actually attend college. Only about one-third of all rural high school graduates in 1959 enrolled in college in 1960 as compared with almost half the urban graduates.[7] These differences persist when rural and urban samples are equated according to the intelligence levels of youth and the status levels of their families.

- ***Lower educational aspirations are most frequent among farm youth and their parents.***

Lower levels of educational aspiration among farm-reared persons may be partly due to the lower educational and economic status of farm families, but also may reflect a lower value placed on education by farm people.[8] In a national survey, equal proportions of males 16 to 24 years old from rural and urban areas (19 percent) gave "lack of funds" as the reason for not being enrolled in school, but the reason "no desire to attend" was given more frequently by farm youth (39 percent) and least often by urban youth (29 percent), with rural-nonfarm being in between (35 percent).[9]

Even in prosperous agricultural areas of the Middle West, proportionately fewer farm boys than rural-nonfarm or urban boys plan to go beyond high school; and the parents of rural youth, whether farm or nonfarm, are less likely than those of urban youth to encourage college attendance.[10] Among farm-reared boys, regardless of family income, those planning to farm are less likely than others to plan for education beyond high school.[11] In Michigan, farm youth apparently regard education as more important for boys planning not to farm than for those planning to farm.[12]

- *Among college students, rural youth may be less well prepared than urban youth.*

National data are lacking for comparisons of the college preparation of rural and urban youth. However, there is some evidence that rural youth who do attend college are usually less well prepared than others. In an extensive review of research on the gifted and talented, Fliegler and Bish report agreement among the findings of several studies that underachievement among college students is related to rural backgrounds.[13] Another study found college entrance scores to be considerably lower for rural than for urban students, and that a greater proportion of freshmen from rural areas entered with academic deficiencies.[14]

Occupational Achievements

- *Rural-reared men generally are less successful in urban job competition.*

Rural-reared men are disproportionately represented in manual and low-prestige occupations. Several studies have shown that the lower levels of education among men from rural areas were mainly responsible for their poorer occupational achievement; but in one, even when farm-reared and urban-reared men with similar levels of education were compared, farm men were disproportionately represented among those working in low-paying occupations.[15]

- *Rural youth usually have lower occupational aspirations than urban youth.*

Comparisons of the current occupations of rural-reared men and urban-reared men now living in cities reflect the experience of the last generation of youth. However, studies of the occupational aspirations of today's high school students indicate that rural-reared males probably will continue to be overrepresented in lower status occupations. National polls as well as findings of studies in a number of States—Kentucky, Michigan, Iowa, Florida, and Washington—show that greater proportions of rural boys than urban boys expect to enter manual, semiskilled, skilled, or clerical occupations. Some of these studies found higher levels of occupational aspiration among urban than rural males even when comparing boys of similar intelligence levels or boys from families of comparable status levels.[8]

Several factors help explain these rural-urban differences in levels of occupational aspiration and achievement. For one thing, rural youth probably are less well informed about occupational alternatives than are urban youth. While systematic data are not available on the extent or competence of counseling available to rural and urban youth, there is evidence that in comparison with urban students, rural students lack access to vocational counseling services and up-to-date knowledge about occupational opportunities, their training requirements, work roles, rewards, and related characteristics. For example, a study in Georgia found rural boys to be less well informed than urban boys about sources of knowledge concerning occupations, and more likely to list informal sources of information, such as friends, instead of formal sources, such as employment services.[16]

In various ways, parents influence the educational and occupational perspectives of their children. Several studies indicate that rural parents are less likely than urban parents to encourage their children to go beyond high school. Proportionately more urban boys than farm, rural-nonfarm, or small town boys have reported that their parents discussed occupational plans with them.[8]

The occupations of fathers and the occupational structure of the community also influence the plans of youth. Farm boys who plan to farm have had intimate experience with farming. Their fathers can help them greatly in their plans. In contrast, fathers of farm boys not planning to farm often cannot provide their sons with much occupational advice. Several studies have found that farm boys planning for nonfarm jobs are less likely than other classifications of boys (urban, rural-nonfarm, or farm boys planning to farm) to have discussed their plans with their parents.[8]

Moreover, in many rural communities, particularly those dominated by farming or remote from metropolitan areas, the bulk of employment is accounted for by only a few occupations, most of which are manual, semiskilled jobs. The youth of these communities have little opportunity to become familiar with a wide variety of work roles.

All of these data point to the same conclusion:

Rural youth need considerably greater help than they are now getting in becoming acquainted with the world of work.

Farm-Reared Boys

Farm boys especially seem to be in need of vocational assistance to decide between farming and a nonfarm job. On the basis of several statewide studies, we estimate that about 40 percent of farm boys plan to farm. However, only about 10 percent of the boys now living on farms can expect to become operators of farms large enough to yield at least $2,500 net income per year.

Regardless of the economic status of the boys' families, smaller proportions of boys planning to farm than of boys planning nonfarm careers expect to continue their education beyond high school. Farm boys usually have considered fewer occupational alternatives, have made their occupational choice at earlier ages, and are more certain of their plans than the other boys.[8] Consequently, farm boys planning to farm appear to be less well informed about nonfarm job opportunities and less actively to be seeking such information.

Studies in Michigan and Iowa found that farm youth who had decided to farm sought occupational information from school sources less frequently than other rural youth and were more satisfied with their present sources and levels of occupational information.[8] Another investigation found them less well informed about the cost of becoming established in several types of nonfarm occupations and about the prestige and incomes of some nonfarm jobs.[11]

These findings may mean that many boys who plan to farm make up their minds without much consideration of job alternatives. They may drift into farming because they think it is expected of them, or because farming is the only occupation with which they are familiar. Their backgrounds, which often include enrollment in vocational agriculture in high school, provide them with little knowledge of alternative jobs.

Most boys who say they plan to farm will not be able to do so. If those who begin farming and later must shift to nonfarm jobs have not acquired a broader education, they will be at a disadvantage in job competition.

Characteristics of Rural Youth

Ideas rural youth hold about themselves, education, jobs, and changes in ways of living influence their plans and their adjustment to urban life and work. Precise and reliable measurements of attitudes and personality characteristics are difficult to achieve, but the limited data available suggest that rural youth, especially farm boys, are psychologically less well equipped than urban youth for living in a metropolitan society.

Take the ideas youth have about work. One study shows that farm boys put greater emphasis on the freedom to be their own boss, whereas nonfarm boys attach greater importance to the intellectual challenge of a job; another reports that farm boys generally prefer to work with things, whereas boys living in towns prefer working with people; and another, that farm boys are less willing than urban boys to accept changes in patterns of living or to move from their communities to take advantage of opportunities.[8]

While some past studies have shown few differences in personality characteristics among farm, rural-nonfarm, and urban youth, recent research, based on more reliable tests, suggests that rural youth are at a disadvantage in relation to qualities which make for success in the world of work. Rural youth in Minnesota expressed greater feelings of shyness, self-depreciation, and suspicion than urban youth.[17] In a Michigan study of farm, village, rural-nonfarm, and urban boys, farm boys showed the greatest indications of submissiveness, shyness, or withdrawal tendencies.[18] Urban boys scored highest on dominance, aggressiveness, self-confidence, and self-sufficiency. These findings suggest another set of differences that may impede the adjustment of rural youth to urban areas and limit their ability to compete with urban youth.

Such social-psychological data, along with data regarding educational and occupational aspirations and achievement, suggest that rural and urban environments have marked, differential influences on youth.

Helping Rural Youth

Clearly, the talents of many rural youth are far from being fully developed, with resultant losses: (1) in the Nation's productivity because of inefficient workers; (2) in the economy because of the necessity for providing for unemployed persons and their families; and (3) in personal satisfactions.

Programs to reduce these losses require modifications in many aspects of rural community life, looking toward two main goals:

1. *The provision of opportunity for all young people to receive an education through high school, suited*

to their individual needs, and, for those with sufficient ability, to receive additional education or training.

To attain this goal requires efforts to motivate every student to achieve his educational potential, develop basic skills, and discover and develop his abilities. In many areas it will require school reorganization, upgrading of instruction, and expansion of special services, especially programs of vocational education and vocational counseling services.

While this process is already underway in some communities, in some depressed rural areas it will require massive injections of outside capital, leadership, and personnel. These are the same areas from which the most poorly equipped rural youth migrate to metropolitan centers for the purpose of obtaining employment.

Readily available vocational education programs are especially needed for rural youth. For young people who have realistic opportunities to enter farming, agricultural education is important, for farming will continue to require increasing levels of management and technical skills. However, the bulk of rural youth need training for work in nonfarm occupations.

Extensive vocational counseling, provided early in high school, is necessary to help rural youth achieve realistic views of occupational choices.

2. *The preparation of rural youth for geographical and social mobility.*

Community leaders in continuous contact with rural parents and youth can help alter conceptions that contribute to the disadvantage of rural youth, especially by emphasizing the necessity for advanced or specialized education. Adult education programs can help rural parents to appreciate the value of education in modern society and to provide more effective educational, vocational, and social guidance for their children.

The challenge to persons interested in the lifelong welfare of rural youth is to develop rural community life in ways that will prepare rural youth for equal competition with urban youth. A broad approach, in the schools, with parents, and with rural leaders, as well as with the young people themselves, is needed to accomplish this end.

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[1] Purdue University, Division of Educational Reference: The Purdue opinion panel poll. No. 57, January 1960; and No. 63, August 1961. Lafayette, Ind.

[2] ———: No. 57, January 1960.

[3] National Education Association, Department of Rural Education: Handbook on rural education. Washington, D.C. 1961.

[4] Purdue University, Division of Educational Reference: The Purdue opinion poll. No. 18, April 1948; No. 25, March 1960. Lafayette, Ind.

[5] ———: No. 21, April 1949.

[6] ———: No. 37, December 1953.

[7] Nam, Charles B.; Cowhig, James D.: Factors related to college attendance of farm and nonfarm high school graduates: 1960. *Farm Population,* Series Census-ERS (P–27), No. 32, July 15, 1962.

[8] Burchinal, Lee G.: Career choices of rural youth in a changing society. Agricultural Experiment Station, University of Minnesota. North Central Regional Pub. No. 142, November 1962.

[9] Cowhig, James D.: Nam, Charles B.: Educational status, college plans, and occupational status of farm and nonfarm youths: October 1959. *Farm Population* (Series Census-ERS (P–27), No. 30), August 1961.

[10] Burchinal, Lee G.: Differences in educational and occupational aspirations of farm, small-town, and city boys. *Rural Sociology,* vol. 26, 1961.

[11] Kaldor, Donald R.; Eldridge, E.; Burchinal, Lee G.; Arthur, I. W.: Occupational plans for Iowa farm boys. Iowa Agricultural and Home Economics Experiment Station Research Bulletin 508, September 1962.

[12] Haller, A. O.: The occupational achievement process of farm-reared youth in an urban-industrial society. *Rural Sociology,* vol. 25, 1960.

[13] Fliegler, Louis A.; Bish, Charles E.: The gifted and talented. *Review of Educational Research,* vol. 29, 1959.

[14] Folkman, William S.: Progress of rural and urban students entering Iowa State University, fall 1955. Economic Research Service, Economic and Statistical Analysis Division, U.S. Department of Agriculture. Agricultural Economic Report No. 12, July 1962.

[15] Burchinal, Lee G.: How do farm families adjust to city life? *Iowa Farm Science* (Iowa State University), vol. 17, 1963.

[16] Payne, Raymond: Development of occupational and migration expectations and choices among urban, small-town, and rural adolescent boys. *Rural Sociology,* vol. 21, 1956.

[17] Hathaway, S. R.; Monachesi, E. P.; Young, L. A.: Rural-urban adolescent personality. *Rural Sociology,* vol. 24, 1959.

[18] Haller, A. O.; Wolff, C. E.: Personality of farm, village, and urban boys. *Rural Sociology,* vol. 27, 1962.

Only by real freedom from need can we give the individual a liberty which is more than formal.

From report of the December 1962 meeting of European Economic Community Conference on Social Security.

How grandparents, parents, and children can contribute to . . .

THE CHANGING AMERICAN FAMILY

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IN different parts of the United States today we have examples of families which, in their structure, represent different periods in our historical development. In some rural areas and among some immigrant groups, we still have the large three-generation family which often includes other relatives; in most of the United States we have the two-generation family of husband and wife and minor children. In both types of families there has been an assumption that it was the adults within the family who, in addition to succoring and nurturing the young, were also essentially authorities on what was right or wrong, correct or incorrect, important or trivial within the culture.

The old three-generation family was particularly suited to cultures with little or no change, where young adults could be supported and guided by the experience of their elders because their own experience was essentially the same. Breaks in such slow transmission of culture came with accelerated immigration from other countries—in which case the young people learned new ways and the grandparents did not—with migration within the society from the country to the city, and with change in social class, a continuing feature of American culture. The two-generation or "nuclear" family became the most flexible and suitable form through which old traditional ways of life could be abandoned and children reared just to the age at which they were ready to go out and involve themselves in a changing world.

It is not generally recognized that we are moving toward a new family form, not yet named and not yet clear. But the conditions which underlie the emergence of this new form are clear enough.

One of these conditions is: an accelerated rate of change so that not only may adolescents and parents expect to see a changed world—a world for which they cannot be prepared in detail—but grandparents must also expect to live for many years in active relationship with a world that is constantly changing. The day of retiring grandparents to a convenient chimney corner or seat at the club to reminisce about the past is departing. For the grandparental generation is the greatest source of information about a problem facing everyone—how to stand change.

Today's grandparents have lived through the most rapid changes the world has ever known. It is not their experience of old, tried ways but instead their experience of the arduous and trying process of continuous adaptation to new ways that is now needed. Once, "I had no grandmother" meant "I know very little about the past." Now, "I have no grandmother" means: "I don't know enough about change. I am boxed in, in a present that I treat as given; I have no time perspective because I don't know enough about what it was like to change from the horse and buggy days of the past."

So the grandparent, who in a great majority of last generation American homes could contribute very little except love and nostalgia to the grandchildren, is now needed in quite new ways, not only

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Condensation of an address given at the 75th Anniversary Year Conference of the Child Study Association of America, March 4, 1963.

in individual family life but also in all of those organizations which support and extend the role of the family in the education of children—child study groups, PTA's, and so forth. Everywhere there is an urgent need for the older people who have changed successfully, have kept pace with the world, who can communicate a sense that something has or could be done.

Supports Needed

The second condition demanding a new form of family is the need for greater support for young couples who have married early and are attempting to bring up children under extremely difficult conditions and for the very large number of one-parent families, faced with an even more difficult task. The breakdown of young mothers who have neither friends nor female relatives nearby has been studied as one index to the increasing precariousness of life in the unsupported nuclear family.

Whether this problem will be met through greater participation in and control over the marriage of young people still in their teens by real or substitute relatives, or how much educational institutions will exchange regulation of individual students' lives for responsibilities for their students' children are uncertain questions. Nor is the question settled of whether our extreme American individualistic style of homemaking, which has produced women incapable of sharing a kitchen with another woman, will be able to generate closer forms of cooperation. But something is definitely needed to end the isolated, exposed position of two very young parents (or one parent alone) attempting to rear several children all by themselves with no one to advise and comfort, no one to take over in emergencies, no one to rely on in regard to the small day by day details of living. This need is of course simply accentuated by the number of these women who are working full or part time and adding a second responsibility—to a job—to the first which is already too much for them.

The third condition is the extent to which parents can no longer control the moral training of their children. The capacity to make a distinction between right and wrong is universal among contemporary peoples and has been claimed to be an essential part of man's humanness. But in a changing situation, each set of parents is hard put to it to give clear moral definitions to their children. The present low standards of ethical behavior in many parts of our society reflect the breakdown of parents' ability to give their children clear ethical direction within a scene that has been changing too rapidly. Moral counsel has become either out of date or uncertain and vacillating.

When TV and radio were brought into the home the capacity of parents to give moral direction to children was much further reduced. *Increasingly, our children are being reared by the mass media.*

Today selective devices by which communities can take over what the individual parent seems no longer able to do—give ethical direction to children's lives—are urgently needed. This will mean the articulate delegation by the individual family of a moral role which it has long since lost, and the development of new ways for parents, teachers, and citizens to take responsibility for protecting *all* of the children of the community, the State, the Nation, and ultimately of the world.

A Shift in Roles

Finally, there has been a shift in the role of experience. Once it was the grandparents who were wisest, then it was the parents reared within the present age who were most able to direct their children. *Now it is the children who are most at home in the world, and the adults who are strangers.* The family needs to be reorganized so that the adults can absorb the children's growing knowledge of the present age—of space, of satellites, of the new mathematics, and of the oneness of this small planet called Earth.

Fortunately, as a nation of immigrants, we have already been somewhat accustomed to learn from our children—who were born here, spoke "American" as a mother tongue, lived here as their immigrant parents never could. We adults still have to give children a sense of right and wrong and a sense that there are some things more valuable than others. But doing this in the world of today and tomorrow will require us to have the flexibility and ingenuity to develop ways in which we can feed back into the family, and into supporting social agencies and organizations, the grandparents' experience of change, the moral responsibility of the parents, and the familiarity of the children with the brand new. This will be a new kind of family grown from conditions that have never existed on this planet before.

CULTURALLY DEPRIVED CHILDREN IN DAY-CARE PROGRAMS

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IN RECENT YEARS there has been growing awareness that large numbers of children in the poverty stricken centers of our large metropolitan areas have difficulties all through their school experience because of lack of intellectual stimulation in their earlier lives. This awareness has reawakened an interest, which ran high during World War II, in providing educational experiences along with daytime care for preschool children, an interest which lagged considerably in the postwar years. Now as the relationship of cultural deprivation to poor school adjustment—and hence frequently to social maladjustment—is becoming more widely recognized, divers groups with all sorts of backgrounds have picked up the torch and are attempting to provide an educational experience for preschool children, especially those of deprived backgrounds. Unfortunately, the eagerness to feed the minds of these children sometimes takes on the aspect of people rushing in with baskets of candy for the starving. The long, slow process of preparation necessary for successful work is overlooked in the search for magic formulas.

When children have been "culturally deprived" they have often also been deprived emotionally as well as materially. Hence the process of helping them to achieve their potential becomes a far more complicated one than merely reading to them for a few hours a day. Experiences in some of the day-care centers associated with the Day Nursery Association of Cleveland can be used to illustrate the complexity of the process.

The Day Nursery Association of Cleveland has been in existence for 80 years. Although its primary function is providing day care for the children of mothers who must earn a living outside the home, it has always engaged in related activities. For example, it started free kindergartens and the training of kindergarten teachers in Cleveland and opened one of the first nursery schools in the United States. Nursery education is regarded as an integral part of the service to all preschool children who attend the Association's centers.

At present the Association operates five day-care centers and, in cooperation with the Division of Psychiatry of Western Reserve University's School of Medicine, a therapeutic nursery school and a kindergarten for children with problems. It also provides consultation through a staff of three specialists in early childhood education to mothers in the selection of appropriate resources for their young children and to various preschool centers in the area, including nursery schools, day-care centers, and schools for such special groups as the hard of hearing, the crippled, and the retarded. Because the Association has found that the education of the young child can be successfully accomplished only by those possessing skill and knowledge, it also offers training and refresher courses for nursery school teachers.

The Association operates on the principle that although children vary greatly in background and in ability a sound nursery school philosophy in which individualization is implicit is as applicable and important for one group of children as another, though different educational emphases may be required. Children who must spend most of their waking hours in a day-care center desperately need the enriching educational experiences that might be expected to be provided by their mother could she be with them. The child who lives in a city slum with crowds of people who have neither the time nor the knowledge to devote to his special needs also requires an enriched background, whether or not his mother has employment. So too do some of the children of the rich, especially those whose parents are constantly on the go and find paying attention to young children alien to their interests. Therefore, the process of meeting the needs of the culturally deprived preschool child from low-income areas involves the same basic essentials as the education of the 3- and 4-year-olds of more privileged background.

The material for this article is drawn principally from day-care centers that are in the heart of the city where a great many culturally and economically deprived people are congregated. One of these centers evolved from a nursery school we ran 25 years ago for yesterday's deprived children. In 1938 we tested all the children then attending, and discovered that they scored 25 points higher than the average reported for all children in the neighborhood by the local public school. Although, undoubtedly, a number of factors entered into so wide a difference, the nursery school experience was probably an important one. Since then we have added to our knowledge about how to prepare children for public school.

The children in these two centers today are there for a variety of reasons. Some have mothers so overburdened by the care of too many young children in crowded and inadequate quarters that they need help with child care in order to be able to hold their families together. More commonly the mothers are the sole providers for their families and must work or attempt to exist on substandard public assistance grants. A few of the children in the centers have been dropped from kindergarten and have been taken into the centers on the theory that a good group experience might help reinstate them.

Learning about fish in a day-care center in Cleveland—one of the many activities which help to stimulate children's interest in the world of which they are a part.

Whatever the reasons for their enrollment, many of these children come from overcrowded homes that are barren of any kind of intellectual stimulation. They are exposed to violence not only through the TV shows they watch but also in their daily living. Their vocabularies may be small but they often include a number of unprintable words. Their knowledge of the real world is confused and magical. No one listens to them seriously and no one really straightens out their thinking. If grownups hear what they say, they are as likely as not either to laugh at them or tell them to "shut up."

Work With the Parents

We have long been convinced that work with the young child must include as much work with his mother as is practically possible. While work with the father is also important, with children under 5 work with the mother is central to any progress. Therefore, the staffs of all our day-care centers include a parent counselor or caseworker. If at all possible, the mother comes to the center regularly: usually she brings and picks up her child daily. In any event, she is expected to come in for regular conferences. In some cases where the mother is sick or emotionally disturbed, the counselor goes to the home.

The centers make a great deal of the informal daily contact with the mother. All staff members are expected to be friendly and supportive, but this does not obviate realistic criticism and demands. With any mother, whether rich or poor, educated or uneducated, a board member or a public assistance recipient, a sense of being accepted as a person in her own right is the key to a working relationship. People who have been culturally deprived have experienced being pushed around, ignored, or rebuffed by the well-to-do and the educated so often that they are inclined to approach a new situation with such persons in authority with the expectation of being belittled. Teachers and counselors both have to make conscious efforts to support the self-respect of the mother as a person and as a parent.

All persons who apply to the nursery for the admission of a child are seen in the beginning by the parent counselor and later by the child's prospective teacher. The initial step in the admission process, after acceptance of the child, is for a staff member to talk with the mother about preparing her child for the new experience. Mothers are advised to make this discussion concrete, giving the child an explanation of why he is going to the center, what he can expect it to be like there, and encouraging him to express his feelings about it all. Many a mother registers surprise at such a suggestion and hotly denies the possibility that the child may find the new experience scary or that he will need her to stay beside him in the beginning. On the other hand, mothers are frequently delighted in the discovery that they can have a real conversation with their children and even more so in finding out how very important they are to them.

Sometimes it takes a long time for mothers to believe that their children miss them. For example:

When the mother of 3-year-old Susie would call for her at the center in the late afternoon, Susie would run in the opposite direction and a scene usually ensued before she went home. One day the counselor said to the mother, "What do you think Susie is thinking when you come for her?"

The mother replied that Susie was thinking how much nicer the nursery school was than home.

"She likes you best," she said sadly.

"But that's not true," the counselor responded. "All day long Susie misses you. She really wants to be with you. She has been so sad and angry because you went away that she can't show you how glad she is you're back."

This was a revelation to the mother. With a little encouragement from the counselor, she told Susie how much she missed her, and she began greeting the child with an understanding warmth that had been lacking in her earlier uncertainty.

Greeting a child warmly is a small and simple thing, but it made a difference in the relationship of this mother and child.

Neglected Children

Some children in day-care centers really do not want to go home, and with good reason. This, for example, may sometimes be true of Tommy, who was 3 years old when first brought to the nursery center by his teenage unmarried mother.

Tommy had been knocked around a good deal by his mother and by his young aunts and uncles who were part of the large family in which they lived. His mother entered him in the nursery so she could work and go to school. She did not expect him to want to go home with her after being at the center, and her fears were corroborated by his screams each day when she came to pick him up.

At the time of acceptance, the caseworker had insisted that the mother be the person to bring Tommy to the center and to stay with him on his first days there. This means of showing the mother that the nursery considered her important to her child proved to be the first step in improving the mother-child relationship. A subsequent one was an arrangement that Tommy be prepared by the teacher each day for his mother's anticipated arrival to take him home.

No caseworker has the skills to change the acting-out ways of a whole family like Tommy's. In this case, however, it has been possible to give the mother enough of a sense of value as a mother for her to begin to have pride in her child. Tommy is a bright and responsible boy, although a difficult one, and has achieved some real successes that have regularly been reported to his mother. Little by little their relationship has improved enough for them to enjoy each other. Now he is usually delighted to see her and they go off happily together. This is not always so—not long ago he screamed for three-quarters of an hour after his mother arrived. But what matters is that the movement is forward. Tommy's mother is now working toward the day when she and Tommy can move from her family and become a responsible independent unit themselves.

Sometimes the father can be drawn into playing a decisive role in broadening a child's horizons. For example:

Charlie, the youngest of a large family, showed all the signs of lack of parental attention. The counselor visited his home and talked with his mother. Couldn't she find a few minutes each day to read to Charlie? The mother brushed this suggestion aside as utter nonsense: She worked and had seven other children to attend to; how could she possibly read to Charlie? The counselor talked to the child's father, who had been unable to find a job for a long time. Couldn't he read to Charlie?

At first the father looked on the idea as absurd. He became interested enough, however, to go to the library and get some suitable books. He tried one out. Charlie was delighted and made comments. The father read some more and found himself engaged in conversations with Charlie.

It had never occurred to this father of eight children that children could be fun to talk to, and now with his last-born, he discovered they could.

This simple kind of approach is time and again surprisingly effective with people who have been uprooted and, in their struggle to survive, have lost the links with the past that might have served as guides for what to do with young children. Such basic beginnings, because they are so simple, are often overlooked by caseworkers and teachers who are searching for more complete solutions or think they can accomplish the task themselves in direct work with the child. Whenever it is possible to remove the obstacles that stand in the way of parent-child relationships it is enormously important, and worth doing. The ancient Chinese proverb that "even the longest journey starts with one step" is worth recalling.

There are, however, some families in which the lack of parental interest is so complete or where the interest is so distorted that work with the parents by the nursery school staff is precluded. Some children come to us from homes where they are not only neglected, but mistreated, and referral to a protective agency is in order. However, if the child happens to be a Negro, unless he is in serious physical danger, there is little use in referring him to a protective agency for possible removal from his home because of the inadequacy in resources for the foster care of Negro children. If the maltreated child has not developed aggressive acting out symptoms which are dangerous to the group, he may be helped by skillful and sympathetic handling in a day-care center. The actual relief that comes from protection, order, and peaceful care for at least part of the day offers him something. The unique feature of a day-care center, as against a nursery school operated as a strictly educational enterprise, is its long hours. This has a special value for children who need protection. The educational experience they get in the day-care center may be even more important.

The Educational Program

All good schools, including nursery schools, correct and enlarge on factual material the children pick up in their daily lives. Children always come to their teachers with some distorted ideas about reality because their experience has been so brief. Nowadays uncensored viewing of TV may add to their confusion. Even children deprived of many basic necessities are apt to be exposed to television. As a result, the Three Stooges, cowboys and Indians, and the strange transformations that take place on commercials form a tangled web of distorted reality in many a child's mind. We had one little boy who thought rabbits laid carrots especially for the supermarkets. In the slum cores of our cities, where few adults take the time to respond to a child's natural curiosity about the unfolding world, the child's conceptions may be strange indeed.

The essence of nursery education is helping a child to learn essential facts about the outer world and the inner world, and how to separate fact from fantasy in order to be able to learn to manage both. Moral standards and attitudes are explicitly explained in relation to actual experiences. Involved throughout, for both staff and children, is that most important aspect of human learning: the art of communication through words. This art is for most of us harder to exercise than we commonly realize.

People sometimes fail to recognize the extent to which language can block communication. Intellectuals sometimes have great difficulty in talking to young children or uneducated adults in terms they will understand. Nursery school teachers often need a great deal of practice before they develop the skill of putting their ideas into words that will have meaning for children. And those who are good at this seem to have a special knack in talking with meagerly educated parents.

In any event language to have meaning must be based on real experience. To have color, it must include feelings. Therefore, the nursery education program includes a variety of everyday experiences of the kind that can be understood by the young. Short trips to neighborhood facilities, parks, fire stations, pet shops, or stores are frequent. The children engage in a variety of creative activities including painting, cooking, and carpentry. They listen to stories. They play with toys. They have plenty of opportunity to talk to each other and the teachers, asking questions and expressing their own ideas. In this way, the ability to use language for thinking and communication is built. From these activities they derive the mental stimulation essential for the preschool child's cognitive development.

People often confuse stimulation with excitement. They think that taking 3- and 4-year-olds to the circus or to see Santa Claus will provide a wonderful kind of entertainment. Actually some children of such tender years will be terrified by such experiences and only become more confused. In fact, one of the positive experiences a well conducted nursery school can offer a child from a teeming city slum is freedom from excitement and a predictable orderly existence.

This was true of Martha and James, two children in the nursery center on a protective basis, who profited greatly from its program.

The mother of these two young siblings had been hospitalized for mental illness but was now at home. She was relieved to have the children out of the way every day. The father was violently cruel and sometimes beat his wife and children. However, he liked the idea that the center would teach the children how to behave and would prepare them for school, and he was willing to bring them there. The most that could be done with these parents was to support their

belief that bringing the children to the center every day was worth the effort.

When they first came to the nursery, James was withdrawn but Martha had violent temper outbursts. Both children were interested in all the play material. They both enjoyed stories. Their difficulties lay in their relationship to others.

Skillful interpretation by the center's teachers gradually drew James out and helped Martha master her temper outbursts. They were told that things were different here than at home: Here nobody hit children no matter what they did; the teachers did not allow children to hurt others or to be hurt by them. This message was delivered many times in various ways. The limits on the children's behavior were firmly held, but they were given free rein to express their reactions verbally. All the while they were learning to do things and were deriving pleasure from their accomplishments. They made friends and they came to trust the teachers.

By the time these children were old enough for public school they had developed sufficiently to make a satisfactory school adjustment.

Some Handicaps

In discussing the education of culturally deprived children it is well to remember that their parents are also culturally deprived, but even so represent as great a variety of individual personality and potential as any other group of people. Many of them, however, have sunk into despair because they are cut off from the mainstream of opportunity in our society. Many had their origins in a very different kind of life than the life they are faced with in the crowded core of a great metropolis and are prepared neither by education nor background for city problems. Most of them are undoubtedly born with adequate intelligence, but too often they give the impression of slowness or even retardation because their intelligence has never been cultivated. The experience of having someone to take a real interest in them and in their children goes a long way in helping their children, at least, to a better start in life.

There are some parents, of course, who cannot profit from this interest. Some do not have the mental capacity to be good parents. Some have become so warped as to find their satisfactions in perverse or criminal acts. A few apparently do not care what happens to their children or get their satisfactions from victimizing them. Some are so disorganized that they could never get their children either to a part-time nursery school or a full-time day-care center on any regular basis. Helping these people is a far more complicated affair than helping those whose central problem is deprivation. Present day knowledge and skill are insufficient to help some of the most distressed.

We must never forget, in our enthusiasm for what nursery education can do for deprived children that there are complex, interwoven social pressures that must also be relieved if any complete solutions to the problems they present are to be found. Poor housing and the dreadful overcrowding that exists in many central cities proliferate problems that block our best educational efforts. Racial discrimination in its many forms has an even more deleterious effect. One has only to listen to children's tragic expressions on how they feel about belonging to a discriminated against minority group to know the bitterness it engenders. For example, a 5-year-old Negro boy told his nursery school teacher he'd rather be a rhinoceros than have dark skin. He said it was no use for him to be smart—he was going to be stupid and not learn anything. Being very bright, he illustrated how this could be accomplished by saying that 3 and 6 made 7.

Blows to self-esteem may interfere with the ability to learn. The inadequacy of public assistance grants and making scapegoats of people who receive them, including their children, also does severe damage to some young children of a kind that is not easily repaired.

In spite of these handicaps to its efforts, a good nursery school, which includes parent counseling, can usually promote a child's ability to learn. The importance of helping children and their parents to exchange their thoughts and feelings in words cannot be underestimated. This can be a central factor in improving family relationships and in fostering a child's capacity for later learning. Moreover, the variety of everyday experiences available in a good nursery school forms a basis for wider learning and expression.

Our inner cities and some blighted rural areas are sources of infection for our entire society. They are danger spots if nothing is done to help the children who live in them. They provide a challenge to educators and social workers, and for the country as a whole an opportunity for proving the real potentials of a free society.

A followup study of children with multiple bone injury provides clues to . . .

IDENTIFICATION OF ABUSED CHILDREN

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THE AMOUNT of systematic research on the problem of child abuse and neglect is conspicuously scant. Abundant material is available about individual mistreated children and particular abusive families but data are lacking on comparable groups of children or families selected for study according to carefully defined criteria. This means that few objective guidelines for child protection have been firmly established; for example, little is known about the long-term effects of abuse on the child or about the nature of the factors which determine the outcome of rehabilitative efforts with the families.

Perhaps the chief reason for this state of affairs is the taboo in contemporary society regarding abuse and gross neglect.[1] The acute discomfort aroused by the topic leads to extremes of emotion and unquestionably accounts in part for the disregard of the subject by research workers. But practical difficulties also stand in the way of rigorous study. One imposing obstacle is the need to decide whether an abusive action has in fact occurred.

Few clinical symptoms can be directly correlated with the mistreatment of children. Abusive acts perpetrated by the children's own parents or substitute parents usually take place within the home where the sole witnesses are members of the immediate family. Aware of society's standards, the abusers do not readily admit to abusive practices. If the child is too young to speak, there is no complainant; if the child is old enough to speak for himself, his listeners may come to conclusions based on subjective feelings instead of seeking the facts in the situation. The credibility of the child's story is also affected by the child's immaturity. Thus the principal basis for identifying the problem has had to be the judgment of the professional person. Judgment is an essential factor but it cannot substitute for objective criteria.

To help in the establishment of such criteria the Children's Hospital of Pittsburgh is carrying out a study of 50 former patients whose diagnoses included multiple bone injuries. A distinguishing feature of this condition is variation in stages of healing of several bone lesions, as shown on X-ray film. For example, a fresh fracture may be observed in one bone, signs of a healing fracture in a second bone, and signs of an old healed injury in still another. The variations in healing stages mean that the bone injuries had to be incurred at different times. This diagnosis has been chosen as the indicator of abuse or neglect in our study for two reasons: (1) multiple bone injuries in infants and young children have been documented in the medical literature as related to an environment dangerous for the child; and (2) experience in Children's Hospital has repeatedly illustrated the same connection.

In our study, abuse is defined as physical assault by an adult against a child; neglect is defined as the

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chronic failure of the adult to protect the child from obvious physical danger. For the sake of simplicity in this paper, the term abuse will be used to cover either situation.

Recognition of the Problem

The development of pediatric X-ray diagnosis extended the possibility of medical identification of abused children. However, the tardy recognition of the problem in medical circles reflects society's discomfort in facing it. In 1946 Caffey reported his observation that subdural hematoma in infants was frequently accompanied by injuries to the long bones.[2] Implicit in this report was the possibility of inflicted trauma as the cause of the patients' injuries. However, the implications of the observation were not picked up by another writer until 1953 when Silverman described multiple bone injuries as " the most common bone 'disease' of infancy."[3] In various quarters efforts were made to pin the entity to organic disease, but these hypotheses gradually proved erroneous. Many reports published during the past 5 years have added to the weight of evidence that infants and young children may be brutalized or killed through the negligence or assault of their caretakers.[4-7]

Experience shows that new fractures are not incurred when the patient is separated from his usual surroundings; that is, when he is hospitalized.[7] In Los Angeles, it has been possible to trace the course of certain patients who returned home after being discharged from the hospital.[8] This has made painfully clear the vulnerability of these children to further traumatization when the environment is not constructively altered. Knowledgeable professional persons now believe that a child with multiple bone injuries has a 50-percent chance of being re-injured should he return to his usual habitat following hospitalization.

X-rays as a Starting Point

Multiple bone injuries have been well substantiated as an indicator of abusive treatment, but certain problems exist in the utilization of the indicator. Identification of the bone condition depends on X-ray film. Although this is an objective tool, it is an imperfect tool when used to define social problems. For example, bone changes, unless gross, do not appear on the film immediately after injury. Reparative changes first appear only 12 to 14 days after injury.[7] Thus, dependence on X-ray evidence as the chief criterion of abuse may result in noninclusion of some children whose environments are dangerous. In this respect, the use of the clinical entity as indicator of abuse has the effect of limiting the size of any study group.

Another shortcoming of X-ray film in identifying abuse arises from the fact that film depicts only the condition of the bones; it cannot testify to other factors crucial to the study of child abuse. For example, the film does not contribute knowledge about the train of events leading to the child's injuries. Such information would throw light on the kind of daily care afforded the child, a factor intimately connected with the frequency and type of injuries to which the child is vulnerable.

Furthermore, important as it is as a clue to possible abuse, X-ray examination cannot identify the person who was responsible for the child at the times his injuries occurred. This may have been a sibling not much older than the patient. While the injury of a child by his sibling does not absolve the adult caretaker from his accountability, failure to prevent an injury caused by an immature sibling implies a different problem in child protection from that presented by adult assault against a child.

Finally, the film cannot define the motivation of the person responsible for the injuries. The intention which leads to an injury may have been laudable: for example, a parent may have grabbed at an infant who was about to roll off the bed. The parent's abrupt action may have resulted in a twisting injury typically found in abused children, but the obvious motivation of the parent was to protect the child. Although one occurrence of this kind is understandable, a series of injuries from such actions is unlikely to occur. Hospital experience shows that protective zeal is rarely a cause of multiple bone injuries.

All these limitations suggest that the radiologic report of multiple bone injuries is a firm starting point for exploration of social factors. Only when other data are added can the identification of abuse be validated. In undertaking research into the social factors associated with abuse, the merits of regarding multiple bone injuries as the first clue to possible mistreatment are:

1. The X-ray film provides a permanent record of the child's injuries. Such a record is less likely to be available when the diagnosis of the child's condition does not require X-ray examination. The diagnosis of simple malnutrition, for example, is not based on X-ray survey. After the signs of malnourishment disappear in response to adequate intake, there is

no objective record of the child's presenting condition, unless photographs were obtained.

2. The varied healing stages of bone lesions is irrefutable evidence that repeated injuries were incurred at different times.

While one injury may reasonably be attributed to a natural accident, it is less plausible to attribute a series of injuries to a series of accidents, especially in a very young child. Since the majority of children found to have evidence of multiple fractures are still infants, their injuries could not have resulted from unsure attempts to walk nor from climbing onto hazardous spots. An environmental factor has to be hypothesized.

3. The clinical nature of the bone findings releases professional persons from undue dependence on hearsay about the care of the child. Since children are frequently used as pawns in adults' quarrels, persons who work with children must contend with all manner of charges and innuendo against parents, often made by disgruntled relatives or neighbors who are retaliating for some grievance.

Few ways have been found to determine the real meaning of many conditions seen in children which may or may not be symptoms of abuse. However, multiple bone injuries, especially in a very young child, are now clinically recognized as a flagrant sign of danger in the child's environment. Without a glimpse of the family or a word of history, the clinician who is confronted with them knows that family factors are of primary importance for the understanding of the child and his injuries.

The Study

The present study grew out of several concerns about patients with such injuries: (1) The patient's physical symptoms often eclipse the acute social problems underlying his injuries, leading the hospital staff to concentrate on the physical injures at the expense of attention to his environment. (2) Hospital administrative policies in respect to these children and their families do not insure optimum management of the problem. (3) When abuse is suspected, few criteria exist for evaluating the family's adequacy for child care. (4) Community resources for abused children and their parents are frequently inadequate.

Our followup study of bone-injured children is designed to learn the present status of the former patients in respect to physical health, intellectual achievement, and social adjustment. Its second aim is to ascertain the kinds of families in which gross neglect or abuse occurs. It is planned as a preliminary to a second study to be concerned with newly admitted patients and their families. In this second study, the operational definitions of abuse will be expanded and comparison groups will be employed. At the present time, the knowledge necessary for choosing appropriate comparison groups is not available.

The identification of the current study group was made by two of the codirectors of the project, a radiologist and a pediatrician, who reviewed the available X-ray films of all patients ever admitted to Children's Hospital. Other children were added to the study group as they were admitted and diagnosed. The criteria for selection were:

1. Multiple bone injuries as shown on X-ray film.
2. Absence of bone disease which might account for the injuries.
3. A history of neglect or assault, or the absence of a history which satisfactorily accounts for the injuries.

Fifty such patients were found.

Among the categories of patients rejected for the study were those whose injuries could be attributed to difficult births. There are no radiologic differences between bone injuries incurred during delivery and those resulting from trauma during infancy and later childhood. This is a clinical judgment based on the age of the patient, his birth history, and his course after discharge from the hospital.[9]

Also excluded were patients who were hospitalized more than once, each time for a different single fracture. For example, one infant had two admissions, the first at the age of 5 months because of a fractured leg, the other at 14 months because of an injured humerus. Staff opinion held that the indifference of his 17-year-old mother could have led to his injuries. However, this patient was excluded from the study group.

Patients with multiple fractures incurred in a single accident were also excluded, even though the accident might have stemmed from failure to provide adequate care for the child.

Strict adherence to the criteria insures that the study group is homogenous in an attribute of consequence: All the children had had repeated injuries, signs of which were discovered during a single hospitalization.

Half the patients were male; half female. Data showing the ordinal position of the patient in their families are so meager that no groupings are possible.

The age of the patients is by far the most striking item of information: the largest group, 17, was under 3 months of age when multiple bone injuries were found; the next largest group, 9, was from 3 to 6 months old. Groups decrease in size as age increases. This is in contrast to the curve for incidence of childhood accidents which shows that the incidence rate for accidents in children is minimal below the age of 9 months.[10] It then begins a sharp climb, reaching a peak between 2 and 3 years, when it begins to level off. This contrast would also seem to support the entity of multiple fractures as an indicator of abuse.

Detailed medical information about the condition of these children on admission has been reported elsewhere.[9] What has happened to them since is indicated by some of the followup data.

Followup Findings

The incidence of death among these children is high. Three infants died in the hospital. Each had multiple fractures of the skull in addition to other skeletal injuries. Four other children died following discharge from the hospital. Two of these four children were slain by their mothers. The third was brought dead to the hospital, and the cause of death was officially stated by the coroner's office as malnutrition. The fourth child, age 5 months, was returned from the hospital to her parents after the court denied a petition to place the child in a temporary foster home. Two weeks following hospitalization, the child died of causes unknown. Thus 14 percent of the 50 children are known to be deceased. Other deaths may have occurred without the fact becoming known to the hospital.

At least three other children sustained additional injury after discharge from the hospital. One had been sent home pending the completion of arrangements for temporary foster care. Within a month she was re-admitted to the hospital because of new injuries, including a fractured jaw. The second child later suffered enucleation of an eye which was injured in the course of a beating by her mother. The circumstances of the injury to the third child are not known.

50 CHILDREN WITH MULTIPLE BONE INJURIES

History Since Admission
Children's Hospital of Pittsburgh

Current information	Number of children
Deceased in hospital	3
Deceased after hospitalization	4
Injured again after hospitalization	3
Physical defect	7
Petition filed for institutional care	3
Retarded mental development diagnosed in hospital	1
Rehospitalized for further treatment of condition associated with original injuries	2
No information of serious difficulties	27
Have returned to outpatient department 19	
Have not returned to outpatient department 8	
Total	50

This table of the history of children since the discovery of their multiple bone injuries through X-rays contains documented hospital data only, and is judged to be a minimum report of subsequent difficulties suffered by the children.

Of the remaining 40 children, 8 have not returned to any department of the hospital since the discovery of multiple bone injuries, and we have no information about them. Of the 32 who have returned, either to the outpatient or inpatient departments, 19, on examination, showed no serious physical or intellectual problem. The information about the other 13 is far from reassuring. Two were hospitalized again for prolonged treatment of chronic subdural hematomas associated with the bone injuries. Seven others had serious physical defects on their return to the hospital; four others were seriously retarded mentally.

Four of the seven children with serious physical defects were permanently crippled as a result of the old bone injuries; the conditions of the other three could not be clearly connected with their traumatic injuries. According to hospital records petitions for admission to State institutions for the mentally retarded were filed for three of the four children known to be mentally retarded. Each of the three was very retarded in development when the multiple bone injuries were discovered at the hospital at their respective ages of 5 months, 8 months, and 12 months. It is impossible to tell whether retardation preceded or followed the traumatic injuries. The other child regarded as mentally retarded had not yet been considered for institutionalization since she was still only 2 years old.

The foregoing account of these children is summarized in the table at the top of this page. Of the 42 patients on whom information is available, over half are deceased, handicapped, institutionalized, or have required rehospitalization.

The Families

Hospital data about the families of these 50 patients are sparse. Until recently, social factors were infrequently explored in respect to children with multiple bone injuries. This was especially true of patients admitted to the hospital 8 to 10 years ago, before the significance of the clinical findings was widely recognized. As the conviction grew that another person had caused the injuries of the child, the medical staff began to focus efforts on obtaining a history of the trauma. However, the relationships in the child's family were not yet recognized as a critical area for inquiry. The number of consultations requested by the medical staff from the social work or psychiatric staffs of the hospital is a rough measure of the importance placed by the medical staff on family factors in the child's condition. Our study shows requests for such consultations were infrequent: they occured for 22 of the 50 children, and most of them were made since 1957.

Several pilot studies have added to the information about some of the children's families who have extensive social agency records, but this subgroup is not considered representative of the group as a whole. One of the tasks of the present study will be to spell out the details of family structure and to learn whether abusive families show any significant configurations.

Our approach to the families is to explain the study as a study of former patients aimed at improving hospital services. Family relationships are being inspected through two structured interviews with the mother, one in the home and one in the hospital at the time of the child's examinations. Data about the children are being obtained from school reports, parents' reports, and appropriate outpatient examinations.

The passage of time since the injuries makes it difficult or impossible to learn much about the circumstances under which they occurred. Whether these families were abusive or neglectful is an unanswered question; but their pathogenic influence on their offspring appears clear in the data available about the children.

Multiple bone injuries will not be found, fortunately in the great majority of abused children. The entity reflects an extreme form of deviant child care. Its mere existence, however, implies a problem of some magnitude. For every child hospitalized with skeletal injuries, there are probably many more whose injuries heal without hospital care. Still others may be subjected to the same kinds of physical mistreatment but may escape injury. This study of bone-injured children and their families is expected to lead to new understanding about children whose abuse takes milder forms, and about families whose child-care practices are deviant, but not to such an extreme.

For a report of suggested State legislation to protect children from abuse see page 202.

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[1] Elmer, Elizabeth: Abused young children seen in hospitals. *Social Work*, October 1960.

[2] Caffey, J.: Multiple fractures in the long bones of infants suffering from chronic subdural hematoma. *American Journal of Roentgenology*, August 1946.

[3] Silverman, F. N.: The roentgen manifestations of unrecognized skeletal trauma in infants. *American Journal of Roentgenology, Radium Therapy, and Nuclear Medicine*, March 1953.

[4] Fisher, S. H.: Skeletal manifestations of parent-induced trauma in infants and children. *Southern Medical Journal*, August 1958.

[5] Miller, Donald S.: Fractures among children. *Minnesota Medicine*, September and October 1959.

[6] Gwinn, John L.; Lewin, Kenneth W.; Peterson, Herbert G., Jr.: Roentgenographic manifestations of unsuspected trauma in infancy. *Journal of the American Medical Association*, June 1961.

[7] Kempe, O. Henry; Silverman, Frederic N.; Steele, Brandt F.; Droegmueller, William; Silver, Henry K.: The battered-child syndrome. *Journal of the American Medical Association*, July 1962.

[8] Boardman, Helen E.: A project to rescue children from inflicted injuries. *Social Work*, January 1962.

[9] McHenry, Thomas; Girdany, Bertram R.; Elmer, Elizabeth: Unsuspected trauma with multiple skeletal injuries during infancy and childhood. *Pediatrics*, June 1963.

[10] Stallones, Renel A.; Corsa, Leslie, Jr.: Childhood accidents in two California counties. *Public Health Reports*, January 1961.

THE CITIZEN'S ROLE IN SOCIAL WELFARE POLICY

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TODAY when it has become relatively easy for the technically trained professional to exclude citizens-at-large from broad areas of social welfare program and policy, it has also become urgent that the degree of citizen involvement expand. True expertise, specialized jargon, bureaucratic organization, and practice rituals all conspire to restrict communication between the professional social worker and the layman as well as citizen participation in programs. Yet the urgency of making deliberate value choices, democratically, in shaping social welfare policy demands that these obstacles be overcome.

The case for citizen participation is usually made from the perspective of the need to interpret programs to the public and to achieve financial support for necessary expansion of resources. These are valid and familiar concerns. But citizen participation which is limited to funding and interpretation does not produce adeqnately informed citizens who have a basis for choice in setting priorities, for achieving balance among program components, and for carrying out interpretation which goes beyond stereotypes. Thus, even these more traditional citizen roles in the welfare field require a base of policy and planning activity.

One arrives at this view whether one begins with the generally recognized need to improve the effectiveness of existing child welfare services or chooses instead to concentrate initially on the demands of a changing social scene. However, let us begin with a brief summary of those characteristics of the social scene and those service problems which demand attention and then note why the citizen's role is indeed indispensible in any strategy for improvement.

The Social Scene

It is not necessary to repeat the familiar statistics which dramatize the phenomena of accelerated social change and their ramifications in family life. Out of world political crises, automation, new forms of mass communication, and widespread social revolution has come accelerated social change at a rate never before experienced. There follows a trail of unanticipated—or at least uncontrolled—consequences: divorce and desertion; out-of-wedlock childbirth; decline in traditonal moralities; community disorganization; personal disturbance; antisocial behavior. Today we face a major problem of communication not merely between generations but between half-generations.

A major intervening factor seems to be the decline of traditional familial and primary group controls and supports. The consequence is an expanding and ever more complex social welfare, therapeutic, rehabilitative network.

All of this occurs under especially perplexing circumstances. For, while voluntary and public intervention and supports necessarily increase in response to social change and desperate need, a significant component of our national ethic continues to be based on ideology and myth which are inconsistent with a call for new or expanded expenditures and services. Through speeches, articles, editorials, and social conversation, views are often expressed which bring social welfare programs and services into fundamental question. Some of these views are that:

- Any well-motivated, employable person can manage to work and support his family adequately at any time and place.
- To arrive at age 65 lacking retirement funds or money for adequate medical care is a sign of personal moral inadequacy.
- Most social welfare needs can be supported on a voluntary basis (or, if public, on a local basis).
- The need for a balanced budget, in the short run, should take precedence over the need for public services, for "the government should balance its budget annually as does any individual."
- Delinquency or mental illness is always a matter of willful deviance, to be treated as such.

There can be no adequate program administration whether on a local, a State, or a national level—nor can there be reasonable planning or priority setting—unless these and related assumptions are reviewed and debated in many forums. It is necessary to decide just what is myth and obsolescent ethic and what is based on current realities. Core societal values need to be affirmed and defended as goals are chosen, while dysfunctional distortions need to be dropped. Social welfare programs, in short, grow out of implicit and explicit policies. A democracy chooses a never-ending dialogue in which differences are honestly faced and choices made. Citizens should not leave this task to professionals alone.

Continuous discussion on many levels of trends, goals, and values might also place at some new point the balance between *child welfare as service* and *child welfare as policy* (or better still, policy for families and children). For sound reasons, child welfare has been a supportive, rehabilitative, therapeutic, direct service discipline which has sought increasingly to concern itself with what public health people call secondary prevention—early case finding and intervention.

One wonders if this continues to be adequate in the face of such phenomena as the early age at which young people are marrying today and the evidence of instability in many of their marriages; the physical mobility of people caused by industrial practices, with the resultant separation of individuals and young families from primary group supports and a consequent high rate of individual and family breakdown; the new patterns for entry and return of women into the labor market and the lack of wholesome substitute care during the day for the children of many working mothers: changing sexual mores and the resultant one-of-wedlock birth rate among teenagers; the migration of underprivileged, rurally reared groups to the deteriorated inner cores of cities in the search of self-improvement, with a resulting high rate of social disorganization among them.

To respond to these trends only in terms of therapeutic-rehabilitative services—much as these do need support and expansion—is to demand an impossibly large increase in such services, to ignore social realities which create predictable problems and needs, and to miss preventive possibilities. It is also to define people in need of service as though the problems resided only in personality, character, or individual adjustment and not at all in social status.

Institutional Provision

While continuing to strengthen case services, had we not better become more inventive about institutional measures to prevent social breakdown and support sound development? Without advocating or endorsing any specific measure, one might suggest *possibilities* (of which there are many) by way of illustration:

- Programs for more adequate family life preparation at the high school level.
- Efforts to strengthen family life through a variety of social supports and educational efforts related to the period immediately before marriage and through the early years of the first child.
- Social insurance for a child against the hazard of losing a parent in the early years or of being born out of wedlock.
- Community socializing devices to support teenage development and assure a measure of control in the many situations in which the "cut off" of family control is in the preadolescent years or early adolescence, and the vacuum is not filled until adult responsibility impinges: for example, more camping opportunities for teenagers.
- Substitute homemakers, home helps, emergency baby sitters, and the like, on a scale never considered in this country, dedicated to supporting the family unit at points where it is now broken all too easily for lack of needed buttressing.
- Social supports for new primary groupings in public housing, schools, block organizations, neighborhood mobilizations, and the like, so that people with common interests may shape neighborhood norms and goals and establish the social stability which once came from the extended family.

This listing is presented only to emphasize the policy role and potentiality of voluntary and public child welfare agencies. In effect, a community (or a State, and, in some instances, a nation) at any moment makes two interesting types of decisions related to social welfare: (1) a decision as to which problems or needs are to be handled on an individualized case basis and which through more generalized social provision (and which case services are obtained by the individual after diagnostic evaluation and which as objectively achieved insurance type rights); (2) a decision as to the location of the "floor" beneath which family and child life will not be permitted to sink. This "floor" determines when protective services come into play, how public assistance budgets are set, when courts adjudicate delinquency and neglect, and so on.

The expanding social welfare component in modern American life means that these are crucial decisions of great significance to each locality and to the Nation as a whole. Should they not be made more consciously? Should not the implicit premises be smoked out periodically and deliberate decisions made? Here, in short, is a basic charge for social welfare policy and planning personnel and for agency administrators. Even more important, here is a creative, vital, indispensable role for citizens on the boards of public and voluntary agencies, and special commissions and committees—a role which, in the last instance, they cannot delegate.

The decision as to pace, extent, balance, and boundaries between institutional and individual case approaches to social problems (or between provision for developmental opportunities and therapy) truly reflects a complex interplay of knowledge, values, staffing, power. The citizen's rightful role in this determination should be recognized and restored, even though professional knowledge and bureaucratization create forces on the side of ignoring the citizen.

To clarify just how to formulate and protect the citizen's role in social welfare is not simple. However, it is clear that legislators and officials on all levels of government need to be encouraged to carry on a policy dialogue and to determine the wishes of their constituencies. Where there is a policy vacuum, previous practice will continue unchanged or the technician will take over. Where there is no true dialogue, a few loud-voiced spokesmen, whatever their persuasions, tend to speak for all.

Equally as important as what occurs in legislative halls and in the executive offices of government is that agency boards, committees, and commissions on all levels, public and voluntary, relate themselves to policy as well as to budgets, to intake criteria as well as to program interpretation, to adjudication criteria as well as to personnel practices, to program direction and priorities as well as to quality of service. Therefore, professional staff members must find ways to explicate the implicit premises in their criteria and practices in order to introduce them to their boards as legitimate matters for policy decision and to open up other possibilities and alternatives.

Policy determination with an eye to the future, based as it is both on technical knowledge and on value choices and projections, means planning. To define, provide for, and support the citizen-at-large role in the sense here suggested is to expand family and child welfare from policy to planning. And planning is essential unless we wish to continue to refine skills without any assurance of making an increased impact on the key phenomena and problems of our times.

Service Planning

A planning process, technically staffed but involving citizens in the policy determinations, might also begin with—or would certainly soon turn to—the key problems of agencies' responsibility and accountability. The technician left to himself is always in danger of becoming preoccupied with process, ritual, and operations and forgetting the task to be accomplished, the goals to be achieved. All professionals do not behave this way, of course, but they all need constantly to protect themselves against the temptation to do so as well as against the normal pressures stemming from specialization and segmentation to assume responsibility for only part of a process. The field of social welfare, by definition, is assigned community tasks and therefore needs always to be goal-oriented. Professional goals and ethics aside, there is disturbingly abundant documentation of the degree to which:

- Cases are found, but opportunities for service are lost.
- Services for an individual client are chosen through an often irrational and haphazard system of shopping around, worker competition for available resources, and chance.
- Children and families are "lost" in the gaps in services at points at which no one is technically "responsible."
- Major defects impair the continuity of care and continuity of concern for the individual case, in relation both to *concurrent* services in several agencies and *sequential* work from one agency or bureau to another.

Family and child welfare programs have been affected by the new concern everywhere in the social welfare field, especially in mental health organizations, for case integration and program coordination. Along with this concern has come recognition that case integration and continuity of service require administrative devices for assignment and assurance of accountability for the specific case.

Where is case integration and program coordination to originate? Are administrators and board members to add this to their current concerns? Much will of course be accomplished where persons who are associated with a given operation pursue the internal logic of agency adminstration and direct-service activity and come to understand the urgency of continuity and integration within the parts of their own operation. Even more will result as staff and board see their agency as part of a community-supported, task-oriented system of services, accountable for results and effective only as each component recognizes that it is a link in a network striving to deal with complex phenomena.

In addition, however, localities and State and national governments need to design a strategy for looking periodically beyond individual agency functions, assigned tasks, traditional services, and even new services, taking as their point of departure a social problem which has become a public concern: for example, the disorganization of family life with special reference to its impact on children. Such a raising of sights may yield new leads for services, programs, and professional training as it contributes to policy formulation and planning.

Citizens who come to social welfare policy, planning, and coordination either from the perspective of a service agency or from alertness to social change meet and interact in welfare planning councils, State commissions on children and youth, governmentally appointed advisory boards and commissions, and specialized "watchdog" agencies in specific functional fields. The experience of the past decade suggests the need to adapt the structure, staffing, and prospectives of such groups to a changing scene in which there is attention in the public sector to:

- Program coordination in the executive arm of government, involving department heads brought together by a chairman powerful enough to give leadership and to assure implementation.
- A citizen policy forum in which representative and informed laymen give expression to the values, priorities, goals, and concerns which should guide coordination and planning.
- A technically qualified research and planning staff serving these two functional units and carrying out planning activities in the executive branch.

While the exact format for these units must vary with State and locality, as must the structure for voluntary plannings and its correlation with the public, each of the possible patterns presupposes some guarantee that citizen concerns and values become decisive factors in policy and planning. For, while social welfare programs will continue to reflect professional knowledge and expertise, they must ultimately be instruments of community policy and objectives.

In focusing on the citizen's role in planning and policy, I do not mean to belittle the traditional and valuable contributions of the direct-service volunteer. Such volunteers, with their intimate personal acquaintance with programs, also have an especially useful contribution to make to definition of needs and evaluation of social provisions, especially at the local level. But all citizen participants in policy and planning need not and should not have concurrent direct-service connections with the agencies and fields in which they serve. Indeed, the direct-service volunteer in a planning role is at times limited by the program identification and special relationships to administrative staff which inevitably evolve through the service experience. Thus while all laymen on boards, committees, and other planning bodies need to find ways to *know* and to *understand* the meaning of services, their particular relationships to a given service or program should be defined in a way that will give them the perspective to support the role they are playing.

Both direct-service volunteer and board-level participant in policy and planning represent, at any given moment, a *community presence* in relation to a social welfare service. Such a presence dramatizes the public's interest and concern and symbolizes its full participation in a network of service and institutional provision. In a modern democratic society client, staff, and board may become the same people at different times and in different relationships. The offering and taking of service becomes increasingly the extension and acceptance of a right. The development of new social provisions reflects community decisions in which all segments of society begin to have part. The issue then is not whether the citizen should have a policy role in social welfare but rather how the role may best be supported and implemented.

A discussion of Dr. Kahn's recently published book, "Planning Community Services for Children in Trouble," appears on page 196.

SOCIAL ADAPTATION IN HEMOPHILIA

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FOR THE PAST 2 years the Medical Center and the School of Public Health, University of California at Los Angeles, have been studying the social and vocational adaptation of the hemophilic adult, a study which has many implications for the care of hemophilic children. The project, supported by a Federal grant from the Vocational Rehabilitation Administration, has been conducted in two parts. Under the first part a questionnaire survey was carried out on 1,100 hemophiliacs aged 16 and over. The 100 questions had to do with their vocational, educational, and social experiences.

The second part of the study has involved detailed investigative interviews with 40 hemophiliacs who were selected as representing relatively good or poor social adjustments. The focus of this phase, to be reported on here, was to learn more about the relationship between early childhood experiences and broad social adjustments in later life. The authors recognize that such recollections are of limited value, since adults recall their earlier life selectively. Nevertheless, these memories seemed worth exploring as having significance for parents and professional persons concerned with children with chronic illness.

Genetic and Medical Aspects

Hemophilia is an inherited disorder of the blood in which a vital clotting factor is lacking. It is transmitted through the mother to male children and usually makes itself apparent shortly after birth. About 60 percent of the known cases have a family history of "bleeders," but the other 40 percent are "new" cases which have arisen presumably from genetic mutation or perhaps from hidden inheritance through generations of female carriers. At present, there is no way of detecting female carriers by laboratory tests, or of identifying potential mutation subjects.[1]

Contrary to our expectations, the family experiences of known hereditary hemophiliacs were not significantly different from the experiences of the "mutants." The mothers in both groups were generally more protective and attentive than the child felt necessary. Mothers who felt guilty because they knew they were carriers showed no significant difference in their mother-child relationships than mothers who had not known they were carriers. Nor were mothers who had known a hemophilic father or uncle significantly different in this respect from mothers who had never known anyone with hemophilia before its diagnosis in their son.

Most of our subjects could vividly recall the change in medical management that occurred with advances in blood-banking techniques. Up to 15 years ago, hemorrhages resulting in painful swelling, unless extremely severe, were seldom treated by doctors. During bleeding episodes the young hemophiliac usually stayed in bed, with home remedies for pain being administered by parents. If the bleeding was massive and pain became unbearable, the child was hospitalized. The incidence of death from continued bleeding was high. Parents and children lived in constant fear.

Today medical treatment can often shorten bleeding episodes, prevent some residual damage, and lessen the crippling effects of hemorrhages. While the possibility of death from bleeding has not been

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altogether eliminated for hemophiliacs, the new treatments have greatly increased their life expectancy and chances for productive living. Nevertheless, the hemophilic child typically has recurrent and unpredictable episodes of bleeding that halt the usual routine of life. He is constantly exposed to doctors, clinics, and hospitals. To date, there is neither cure nor the possibility of prevention.

The Study's Subjects

Hemophilia was diagnosed at birth (or within the early months of life) in about three-quarters of the study's subjects. Early symptoms of external bleeding had usually been noted at circumcision, but as the child developed, internal rather than external bleeding was usually his major problem. While just sitting up could cause tender hematomas, spontaneous bleeding beneath the skin or from internal organs was the most disruptive problem in early childhood. Internal bleeding was experienced as more limiting, painful, and disabling than bleeding from external wounds. If, in the recollection of our subjects, the bleeding involved a knee or ankle joint, countless periods of extended bed rest, transfusions, and other medical treatments were required. Bleeding which affected joints in the upper extremities, such as elbow, shoulder, or wrist, were easier to live with in childhood, they reported, since this did not require them to stay in bed and so be separated from the family and its routine.

Because hemophilia is little understood by the general public, it is often feared that hemophiliacs will bleed to death if externally injured. Hemophiliacs themselves, however, are more concerned about the "spontaneous" internal hemorrhages of unknown origin. Sustained problems from internal bleeding such as permanent loss of sight from a hemmorrhage into the eye, or permanent kidney damage, were found in members of our study group, but most common were orthopedic disabilities, such as a rigid ankle or knee joint resulting from recurrent internal bleeding.

Despite these problems, many hemophiliacs learned early in life to conceal the fact of their illness as they became aware of people's fears about how gingerly they would have to be handled. Concealment was practiced in childhood to gain acceptance from peers; in adulthood, to avoid rejection from potential employers and social acquaintances. Our subjects drew parallels between the consequences of their misunderstood and limiting physical disorder and of such disorders as epilepsy, deafness, or cardiac disease. Thus, the problems of the hemophilic child do not seem to differ greatly from the problems faced by others who are chronically ill but normal in appearance.

Parental Supervision

The patterns of parental attitude reported by our subjects could be placed in three broad categories: (1) overprotective; (2) realistic or permissive; and (3) indifferent. They saw the roles of mothers and fathers very differently. Mothers were usually expected to be overprotective and to set limits on their young sons' activities because of their fear of physical danger. The fact that mothers had caused them psychological trauma by saying "no" was more easily accepted—"she wasn't a boy ever and couldn't be expected to know how important this game was to me"; but fathers who repeatedly denied physical activity were described with great resentment. They were regarded as traitors to their sex and as having denied the masculinity of their young sons.

When parents had differed, mother saying "no" and father "yes," the boy had felt he was masculine like his dad; but when both parents were overprotective, the boy's urge to maleness or independence had been throttled. The fact of parental disagreement seems to have been less important to the child than the emotional support he felt when his father risked the unknown and recognized his developmental needs.

One of the most important findings of this study was that the key to achieving social competence and independence for the hemophilic boy is a father (or father figure) who recognizes his maleness or who does not show concern about his activities. Among our "good adjustment" group, fathers were remembered as either permissive or indifferent, but among the "poor adjusters" (classed as dependent-unemployed, and usually living in the parents' home), overprotection from both parents was commonly described.

Childhood Experience

"Can my son have a normal personality development in spite of his hemophilia?"

This is one of the first questions asked by parents of a hemophilic child. Recent research and theory in behavioral science would indicate that the answer to this question is influenced by many factors.

In our own research, the elements regarded by hemophiliacs as most strongly influencing their personality development when young was the parents' attitude about permitting normal childhood play. Whether special provisions made within the family for the sick child encouraged or played down a sense of difference was also highly important. While these factors were not the sole contributors to adult adjustment, they were the chief factors stressed by our subjects.

Most of our subjects had been diagnosed as hemophiliacs very early in life and reported they had "always" known they were "different" from other children. The degree to which they felt different did not correlate with the number or severity of illness episodes they had experienced, but was associated with the degree of isolation they had experienced or of restriction from kinds of activities boys usually enjoy. Most of our subjects reported they had been capable of setting their own limits of activity "by the age of 6 or 7" because the consequences of injury were so painful. They could not protect themselves against spontaneous bleeding, but could and did avoid body contact injuries. In remembering injuries which occurred when they "broke a parent's rule," they said that often it was not the prohibited activity *per se* that brought about painful consequences, but the tension caused from disobedience. They also reported that as adults they were similarly accident prone when under tension, but competent in self-protection at other times.

Another key to feeling "male" lies in sharing experiences with other boys from preschool age until adulthood. A large number of our sample of "good adjusters" felt that their parents encouraged them to join with other children, while most of the "poor adjusters" recalled parental opposition. If not permitted to join other children because parents consider the risk too great, the hemophiliac, who like any child wants to be with other children, internalizes the concept of being "totally different" instead of a child who has a difference but also has many likenesses to his peers.

Even when very young, the child with a *visible* handicap can be accepted by other children without being expected to join in all their activities; but the "normal appearing" child has no visible excuses. Since most young boys' play is gross motor activity, the issue of how far the hemophilic child can go is posed early and decisively.

The key problem for parents of hemophiliacs is in drawing a fine line between necessary caution and harmful overprotection. When our subjects were asked what advice they would give to parents of hemophiliacs, many stressed the importance of developing independence by allowing the child to learn himself what his limits are. One subject advised, "Try to teach him self-discipline and give him lots of love." Another commented, "I knew what I could and couldn't do, but my parents felt my body should be wrapped in cotton-wool, even if it meant missing all the good times kids need."

School Experience

The years from age 6 until the teens were recalled as their hardest by our subjects. In this period they derived little gratification from being good students, since their peers placed a much higher value on other accomplishments, especially in athletics. Most of our subjects considered themselves scholastically advanced as children because they read a lot when they could not play. On the other hand, they had attended school only irregularly, and had obtained little satisfaction from their schoolwork. Those who had gone to schools with large structured classes had had more difficulty in school adjustment than those who had attended one-room schools. The latter, being in classes with children of various ages and grades where students were expected to learn different things, did not feel conspicuously different when the teachers individualized their work for them.

The grade school years were usually evaluated by our subjects according to how much activity they missed and how excluded they had felt. If the parents restricted or forbade after-school play, the youngster felt alienated from his peers. But the child who because of his parents' intention or indifference was allowed to join other children had a chance to identify with other boys.

Three men in the sample who had not attended school beyond the third grade are employed and finding satisfaction in adult roles, and so are classed with the "good adjusters." All three reported that when they were children, their parents had expected them to act like boys even though they were too ill to go to school.

The following case stories illustrate contrasting parental approaches and their effects.

Mr. P is a pale, thin, attractive man with no apparent physical deformities. He lives with his widowed mother and his married sister and her family. He spends his day viewing TV, reading, or "just doing nothing but watching people pass by on the sidewalk in front of the house."

When he was a child, Mr. P was never expected by his parents to do anything except watch. He was not allowed to play with other children for fear he would get hurt. By the time he was 6 or 7 he was afraid to join the neighborhood boys because he did not know how to play their games with them. Gradually he withdrew to watching through the window.

At age 10, Mr. P was enrolled in school for the first time at the recommendation of the local school authorities, but was so frightened by the "big kids" that he never returned to class. His parents made no effort to send him back. He received what education he got from a home teacher and from correspondence courses in accounting and bookkeeping. When he was 24, he tried to work for 3 days but quit because the office crew were not especially cordial and because his parents felt he should not "push" to get to the office by 9 a.m.

Now at 32, Mr. P feels that life is passing him by. He has nothing to do and no interests. His family still tends to watch him if he tries to sweep the porch or carry out the garbage because they fear he will hurt himself. He wishes he had been expected to play outside, to assume household chores, to attend public school, to develop active hobbies, instead of being encouraged only to protect himself physically.

. . .

Mr. A, age 35, walks with a pronounced limp and carefully lowers himself into a chair. He came to the interviewer's office after working hours. He is a tool dyer and has been employed in the same firm for the past 9 years.

Mr. A described his childhood as "never having a parent at home." His father seldom "bothered to come around" and his mother "was always working or out." He had many episodes of bleeding into weight bearing joints as a result of which he often used crutches. He did not attend school because no "truant officer bothered us after the years I had been in the hospital" and my parents "weren't around to make me go."

Mr. A remembers waiting each day for 3 o'clock to come around, for then the neighborhood boys would be home and he could play with them. He liked fishing and sliding down sand hills on boxes, but best of all he liked just being with his "buddies."

Before he reached his teens, Mr. A was "hanging around a garage" with older boys and developing a skill in fixing cars. Once in a while he helped his father, who was a mechanic. Since crawling under cars was too difficult for him, he gradually converted his interests to tools. Though he had no formal training as a tool dyer, he made himself into a tool expert, and is now proud of his earning capacity and his productivity.

Even though Mr. A's "indifferent" parents did not provide him with much love and security, he became an apparently competent person because they did not smother him or isolate him from social contacts.

Teenage Experiences

Among physically normal children, adolescence is frequently an emotionally painful and difficult period, but, as Beatrice Wright [2] has shown, this is not always true of the handicapped child.

Our subjects generally found the teen years easier than their earlier years. Many of them made their first fully reciprocal and satisfying friendships then. Formerly, play activities were chiefly physical, but in their teens many of their peers had hobbies and interests which they could share—stamp collecting or motor cars, for example. Scholastic accomplishment now had rewards, since in some high schools the "bright" student with a broad range of knowledge may attain status.

The feelings about being "different" did not disappear but did diminish as the hemophiliacs grew older and found more bases for social relationships. Gradually they became aware that other boys were also feuding with their parents over limits on independence—hours, use of the car, family participation—and this was reassuring because it helped them experience a bond with their contemporaries.

In the course of adolescence, peer group approval became as important as paternal approval had been earlier. If allowed to mix with other teenagers, the hemophiliacs tended to adopt the peer group outlook on employment, schooling, and other topics.

Cars had an even greater meaning to the hemophilic teenager than to his unhandicapped compeer. The democracy of wheels served both as a leveler and as an opportunity for increasing social status. There were many more drivers among those of our subjects classified as "good adjusters" than among the "poor adjusters." In addition to its practical value, driving seemed to help the handicapped teenager to express his desire to be like and to spend time with his peers.

Vocational Counseling

Gains from having had professional vocational counseling were noted by some of our subjects, but the timing of counseling interventions was often regarded as inappropriate. Many of our subjects had not received help in vocational planning until they were in dire need of employment and were seriously disadvantaged by their lack of skills or education. Vocational counseling had been beneficially used by 8 of the 40 hemophiliacs interviewed, but the most helpful counseling was reported as having been started during the junior high school years (ages 12–15). During this age period, the youngster could accept a trainee or student status because he was at an age when young people are expected to be financially dependent and when school attendance is the usual routine of his age contemporaries regardless of their financial status. The hemophiliac who did not have vocational discussions until he was in his late teens often felt then that he was too old to start a long educational program and went into unskilled work. Many of our subjects commented that "they [the counselors] waited until it was too late for me to change."

Help in early vocational training and planning was regarded by our subjects as necessary in a total treatment program for persons with a chronically limiting disorder. They described the ideal vocational counselor as one appropriately informed both about job prerequisites and potentials and about the limits imposed by specific diseases. However, they stressed the fact that *the self-image of the patient has to include being potentially employable before he can respond to vocational guidance and training in a realistic way.* Again, we were made aware of the family's great influence on individual potential for independence and competence.

Our subjects included many young adults who had found work on their own, some of whom recognized they had made poor job choices because of lack of guidance. Also included were hemophiliacs who had received vocational guidance and training, but who had not sought employment because they felt unable to work in the field of their training. Isolating occupations, such as watch repairing, were reported to be bad choices because the handicapped person needs to make social contacts through his work experience; moreover, for hemophiliacs constant sitting, in a confined area, may be physically damaging. Self-employment, after enough training to permit work at a livable level in occupations in which frequent absences would not matter, was often cited as ideal for the hemophiliac. Twenty percent of our subjects had attained this goal.

Here is one success story:

Doctor Z is a research chemist with a commercial drug firm. As a young child he used crutches occasionally and was confined to bed frequently, but he "made it through high school." His family expected him to help on the farm, and he managed both chores and schoolwork. During high school he showed interest and ability in the physical sciences, and the school guidance officer encouraged him to compete for a scholarship to college. The undergraduate course took him 8 years due to dropouts from illness, and the graduate work even longer, but he is now well established.

Doctor Z supervises a research laboratory and explains that he can "supervise by telephone for a few days when necessary." Married, with young children, he assumes a responsible position in the home, in the community, and on the job.

Doctor Z advises young people with chronic handicaps to expect to reach educational goals more slowly than others, rather than to take on the unrealistic burden of trying to keep up with other students.

Rehabilitation and Counseling

Most State departments of vocational rehabilitation extend services to handicapped persons who have reached the age of 16; but many persons who have had lifelong handicaps do not make application for services until much later in life. We saw hemophiliacs who were unaware of this source of help, who felt too defeated to try to qualify for training, or who were likely to continue to be dependent the rest of their lives because they were unable to visualize a different role for themselves. With some intensive help, these men might be rehabilitated to gainful employment, but at their age changing a dependent to an independent self-image through counseling is a long and difficult process.

Complex life adjustment problems obviously confront every hemophiliac as well as other chronically ill persons. If a professional counseling service were readily available at the time of diagnosis and thereafter, parents would have the opportunity to explore their reactions to the handicapped child, to gain emotional support during crises, and to learn to plan and provide a home climate that fosters independence and growth. This preventive approach would reduce the necessity for rebuilding a damaged self-image in adulthood. Somewhere within our public and voluntary efforts for handicapped children, we should be able to find the wisdom and resources to implement it.

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[1] Canadian Hemophilia Society: *Hemophilia Today.* Montreal, Canada, Mar. 1, 1962.

[2] Wright, Beatrice A.: Physical disability: a psychological approach. Harper & Bros., New York. 1960.

I think that the major trouble with youth today is an all-compelling sense of urgency; a fear that if you don't see it all, do it all, try it all, in a very short time, you will never get the chance to do it or see it or ANYTHING.

B. C. C., age 17, New York, in a letter to the 1960 White House Conference on Children and Youth.

TREATING CHILDREN TRAUMATIZED BY HOSPITALIZATION

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DURING the past 7 years, the authors of this report have gained considerable experience in the prevention and treatment of the maternal deprivation syndrome in hospitalized infants and young children in Warsaw. This syndrome, sometimes called "hospitalitis," is well-known to persons who have observed young children in institutions and hospitals. It consists of a failure to thrive physically and in social and psychological development, and is a result of the exposure of the hospitalized child to numerous traumatic factors and of the frustration of those inborn needs which are normally met in a family environment. In extreme cases it may be manifested as a general marasmus, or wasting away.

Our experience was gained during clinical work with children in the Institute for Mother and Child, a hospital and research center in the Premature Clinic of the Medical School in Warsaw. During these experiments, material was gathered on the clinical history and detailed psychological examination of 211 children, including 78 children with a severe maternal deprivation syndrome hospitalized in the Premature Clinic's Department of Developmental Pathology and 60 children examined in residential crèches. One of the authors (Izabela Bielicka) gained additional experience with such cases in carrying out her responsibilities as state consulting pediatrician. From these experiences, as well as from data in the professional literature, were formed the theoretical basis as well as the practical outlines for child care during hospitalization which the Department has adopted.

In the Department of Developmental Pathology we see children from a few months to 3 years old who are admitted for care mainly because of severe malnutrition after a long hospital or institutional stay. The technical team consists of two physicians and two psychologists working in close collaboration. The same team works also in the outpatient clinic. In addition, there is a team of 7 nurses, each caring for 10 or 12 children.

The children are cared for in four glass-walled wards and a fifth room which is a common recreation room. In addition there is a wide corridor where they can also run and play. In summer, the children spend 2 or 3 hours daily on a veranda or in the garden. In these facilities the Department trys to meet the children's basic needs—for good nutrition, for sleep, for protection against fear and physical pain, for a sense of security, for mothering, for active exercise and exploring, for visual, auditory, kinesthetic, and touch stimuli, and for play and freedom of movement. We try to enrich the hospital environment by ensuring a diversity of adequate stimuli.

Nutrition

Nutrition is considered a priority problem in the care of our patients. Most of them suffer from anorexia (lack of appetite) and negative reactions to feeding, such as vomiting or other defensive reactions against food. We insist that the feeding of the children should, as far as possible, be carried out always by the same person. During bottle feeding the infant is held on the feeder's lap, thus providing for an association of feeding with a close physical and emotional contact between the child and the adult who is substituting for the mother.

Because of the functional deficiency in digestive glands, especially the pancreas, in many of these patients, the diet is protein rich and often flavored with horseradish, mustard, or mayonnaise. The quantity and quality of the food is regulated by "self-demand," especially during the most severe period of digestive disturbances. As rehabilitation progresses the children become adapted to a more regular regime of feeding.

In our practice we frequently have observed children whose initial severe anorexia becomes transformed into its opposite, wild hunger and fear of food withdrawal. During this period of insatiety the children are permitted to eat as much as they wish, and even to fall asleep holding a reserve piece of toast. This permissive system eventually results in the child's forming good permanent eating habits.

Sleep

We try to ensure our patients undisturbed and deep sleep. Uninterrupted sleep lasts from 7 p.m. to 6:30 or 7 a.m. The morning toilet bathing and room cleaning are performed at 6:30 a.m. by the night and day duty nurses together. During the daytime nap the patients sleep out of doors or at least by open windows. Personnel are forbidden to

Hospitalized children on an improvised slide at the Institute for Mother and Child in Warsaw.

interrupt a child's sleep for treatment or examination.

We believe that a close physiological interrelationship exists between the activity during the waking period and the intensity or quality of the sleep. Therefore, the daytime naps are alternated with periods of intensive wakefulness, stimulated by active play out doors under friendly adult supervision.

Protection Against Frustration

Protection against frustrating factors such as pain, fear, and feelings of isolation is an important part of our nursing system. Friendly and delicate handling during the medical examination and nursing care are regarded as especially important. Coldness, overwarmth, or violent movements of the nurse during diapering, shaking the child or making noise while he is sleeping, forcing him to eat, and, above all, not responding to him during a prolonged period of crying are avoided as repeated microtraumas which lead to discomfort and maladjustment of the child during the stay in the hospital. Technically efficient nursing is not enough to eliminate the damage of hospitalitis. The only way to ensure adequate care of a child in a hospital is to create an emotional bond between the adult nurse and the young patient, thus combining nursing and mothering.

During their waking periods the children are together in a play room and this helps ward off feelings of isolation or other fears even when the "substitute mother" is absent.

The lack of constant care by the mother or a mother substitute cannot be compensated for fully in hospital conditions even if the staff remains mindful of the psychic requirements of the children. In this respect our experience is in accord with the professional literature on this subject and demonstrates that, while drastic forms of hospitalitis may be treated successfully, the child may attain full rehabilitation, especially development of his social personality and speech ability, only when fitted into normal familial home life.

Conclusions

Our observations have resulted in the following rules for child care:

1. The child should be hospitalized only in cases of unavoidable necessity.

2. Orphans or abandoned children should, as early as possible, be placed with families for adoption or foster family care. Foster family care has recently been introduced into Poland by the Ministry of Health and Social Welfare.

3. The hospital doors should be kept open to the mothers of child patients. In our hospital the mothers are encouraged to spend as much time as possible with the child, a policy we have found very helpful in treating the child. We have attained good cooperation between mothers and personnel of the clinic and have not had any infectious diseases introduced as a result of the mothers' frequent visits.

4. In the mother's absence from the hospital, the child should be given into the care of a staff member who serves as a "substitute mother." In our hospital the substitute mother is usually a nurse, but in difficult cases this function is performed by a psychologist. The task of a substitute mother is to build an emotional bond with the child. We have observed surprising improvement in the development and well-being of children after such a bond has been created, and so consider such substitute mothering as basic to our treatment.

5. The nurses' training should include the development of maternal personality traits such as sensitivity to various emotional states in the child, sensitivity to pain felt by the child, the ability to make independent decisions, and the ability to make adequate observations of the child. We regard the ability to form attachments to the patient—a readiness for mothering—as the most important trait of all. According to our experience, this trait may be developed to a great extent through bringing influences to bear which encourage the nurses to demonstrate their own initiative and spontaneous friendliness to the children.

6. The functional needs of the child such as the need for motor activity and for diversified play must be taken into account and satisfied. We should like especially to stress the need for kinesthetic and touch stimuli, which dominates all other needs in early life and is met by cuddling and petting the child. Because we have found that the lack of such stimuli may cause the appearance of early forms of emotional disturbances, especially in premature babies, we try to ensure that the infants spend as much of their waking time as possible on the nurse's lap. We have observed marked improvement in cases of severe psychomotor regression in weak and emaciated children after they have been regularly held and cuddled by a substitute mother.

All these methods used in the Department of Developmental Pathology have proved effective in the rehabilitation of 78 cases of severe psychosomatic disturbances induced directly or indirectly by a period of institutional stay in hospitals or children's homes.

Stimulated by personal attention this hospitalized child takes a lively interest in what he sees.

An essay review . . .

SOCIAL PLANNING FOR CHILDREN AND YOUTH

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IN his recently published book, "Planning Community Services for Children in Trouble,"* Alfred J. Kahn applies the most recently articulated ideas about community service systems for children to specific experiences of States and local communities. While adequately presenting the theoretical formulations which have emerged from academic circles, he, at the same time, takes into consideration the simple fact that most practitioners and interested laymen are focusing on the day-to-day tasks of rendering services to people who need them. Thus he spans the distance that sometimes exists between the academicians and those on the firing line.

The message carried throughout the book is that a "policy vacuum" exists in planning for children in trouble. The author presents this by illustrating the confusing and sometimes conflicting policies in community programs conducted in the interest of children's welfare. He clearly relates the policy needs regarding children to broader policy considerations involving the welfare of the total population.

The search for the focal point in such policy formulations is complicated by the way in which communities have delegated certain responsibilities for policy to community institutions; and thus we often find a condition that permits agencies to define community policy based on agency function rather than on community need. Dr. Kahn discusses the way in which such circumstances evolve.

However, while placing a timely stress on planning to insure the quantity and quality of services needed for children and illustrating the numerous variations in style of planning in community and State approaches, Dr. Kahn does not deal in depth with the ingredients of the planning process nor with any set of assumptions other than those reflecting a desire to improve the lot of children for humanitarian purposes. He seems to accept an innateness in our social system for circumvention and evasiveness in confronting causal conditions. For example, in his discussion of the tendency to bureaucratize service systems, he says:

> In a complex, industrial society, and particularly in its urban areas, the nature of population concentrations, the wide ramifications of needs, the multiplicity of skills required and services offered all lead social welfare programs to that inevitable formal organization . . . which is characteristic of most organizations in the modern world. Wilensky and Lebeaux have reminded us that "red tape, buck passing, inaction, inflexibility," which are ways in which the layman would characterize many of the service problems, are actually pathological manifestations of some of the most basic and valuable features of modern formal organization. In their attempts to achieve efficiency, reliability, continuity, precision, and fairness, organizations are inevitably and increasingly characterized by ***specialization*** . . . ***hierarchy*** . . . an emphasis on ***rules*** . . . ***assignment of roles to specialists*** . . . and ***official designation of areas of jurisdiction*** for the several roles.

Accountability

Dr. Kahn indicates that these tendencies are inevitable although some islands of simple and informal organization do exist. The process of formalization tends to separate the agency and the problem-solving process from the problems and the populations having the problems. Defective service programs are therefore traceable in large part to the "ever threatening psychopathology of bureaucracies" and an answer to this inherent quality of social welfare organization lies in the "organized means for ensuring accountability and service integration."

Dr. Kahn's method of dealing with the concepts of accountability and service integration clarifies his concerns about fragmentation in relation to agency policy. He states that agencies ". . . are instruments of public policy and social control," established to translate basic community concerns into workable programs, and that the practitioners inherit small portions of this community mission of control. However, he maintains that the mission cannot be fulfilled unless the full responsibilities of the community toward the problems are discharged, and that any thing that encumbers this process contributes to the fragmentation of services. Presenting a number of examples of accountability devices and instruments designed to prevent encumbering conditions, he reexamines certain concepts of coordination that at one time seemed useful but today, under the present pace and dimensions of social change, seem less effective.

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*Kahn, Alfred J.: Planning Community Services for Children in Trouble. Columbia University Press, New York. 1963. 540 pp. $7.50.

Coordination

Dr. Kahn's method of treating "coordination" is impressive to one who believes that coordination is a word that has been misused in social work for a long time. From experience in working with agencies having responsibility for coordination, this reviewer is convinced that much depends on authority, responsibility, lines of communication, and other factors between the coordinating body and the services being coordinated. To simply cite the need for more effective coordination is much simpler than to detail explicitly the procedures that will bring this about in any particular community. Yet the mechanism for coordination is an important element in reaching an adequate service system.

Largely because of the stresses generated by interaction between cooperating agencies in States and communities, long-term permanent coordinating agencies have found it difficult to keep pace with the changes in community organization indicated by rapid social change. The hiatus between service systems and consumers of service, widened by the growing dollar gap betweeen middle and low income segments of the population (and the apparently growing disparity between income levels of white and nonwhite families), puts new dimensions into the meaning of coordination. At the same time, it calls for different, imaginative uses of instruments of coordination, such as money and the methods employed for its allocation. And, it raises new questions about the composition of local "power structures" and their systems of delegating decision-making responsibilities.

Although Dr. Kahn does not elaborate on such questions, in his discussion of planning he obviously recognizes their pertinence to his conclusions.

Planning

The familiar plea for planning runs throughout the book. In illustrating different approaches to State and local planning, the author underscores the need for more effective approaches. However, here there is a rather serious omission.

The most difficult problem in planning is the construction of the means through which communities can achieve the working relationships required for implementation of a broad plan. In fact, the discovery and analysis of these means cannot be separated from the total package of planning responsibilities. Therefore, a discussion—missing in this book—of the relationship between the economic and political facts of life to efforts to enhance the welfare of young people would seem to be relevant. An examination of the broad ing in this book—of the relationship to a broad community policy for youth, could reveal some interesting features of community values as they are translated into programs.

Because all programs are ultimately translated into dollar costs, an examination of the question of whether the short-run business interests that form a large part of the local community economic base are inherently disruptive of social planning would be beneficial. Similarly, with much of public policy determined by political functionaries, the author's stress on planning needs might be better understood if accompanied by some connecting analyses of political processes at the State and local community levels. The balances which must be achieved between varied forces in a community in order to implement a welfare program must include balances within the political and economic segments of the community.

Dr. Kahn's final note about planning—that "consumers of service" have a contribution to make—might well have been presented in the light of the insistence today on the part of many consumers on their right to a place at the decision-making tables. Whether planning is addressed to physical or social community needs, planning for and around rather than with the consumers of service may, in the long run, be more costly than the traditional, fragmented approaches to social planning.

On Delinquency

One of the book's most impressive discourses deals with the various theories of delinquency causation and prevention existing today. Avoiding an entanglement with the relative merits of these, the author states: "Clearly, many of the theoreticians are accounting for different aspects of the phenomenon, for different delinquencies." As he discusses programs for intervention, he takes into account many etiological theories, stressing that systems of classification of delinquents or delinquencies cannot be the sole basis for prescribing the most appropriate form of community intervention.

Dr. Kahn seems to support the current trend toward the development of broad, comprehensive approaches to the problem with carefully structured methods of program evaluation. In referring to "ultimate, intermediate and immediate levels" of prevention, he notes the impact of broad social forces. But he considers the "ultimate level" outside the scope of the book, and places emphasis on a discussion of those levels responsive to local and State action. Thus, having built a beautiful case for the integration of delinquency prevention and control programs with programs designed to affect trends, such as mobility and urban growth, he confines his attentions to the former.

In general, one is impressed with the potential utility of Dr. Kahn's work to all concerned with playing a useful role in the community's responsibility for the young—whether through the courts, social agencies, schools, community groups, health services, or at home. Many writers have dealt with the same delicate subjects only through negative criticism of institutional services and functions. By contrast, Dr. Kahn leaves the impression that these are part of a predictable developmental pattern calling for "firm public policy and support" to tip the balance toward progress.

BOOK NOTES

THE MULTI-PROBLEM FAMILY: a review and annotated bibliography. Benjamin Schlesinger, with essays by John C. Spencer, and Joseph C. Lagey and Beverly Ayres. Florence Strakhovsky, Editorial Consultant. University of Toronto Press, Toronto, Canada. 1963. 173 pp. $4.

Out of the literature on troubled, dependent families—of Australia, Belgium, Britain, Canada, France, the Netherlands, and the United States—the author, assistant professor, School of Social Work, University of Toronto, has compiled an annotated bibliography, introduced by two essays that attempt to give perspective on such families.

The first of the essays, by a professor at the same school, traces development of the concept of "the multiproblem family" as well as variations and some common denominators in the approaches of these nations to defining, treating, and giving services to them. The other essay, which lists programs in 143 communities in North America, is by two staff members of the Community Chest and Councils of the Greater Vancouver (B.C.) Area.

The items in the bibliography, which go up to November 1, 1962, are grouped according to country, then alphabetically by author.

FAMILY AND MENTAL HEALTH PROBLEMS IN A DEAF POPULATION. Edited by John D. Rainer, M.D., Kenneth Z. Altshuler, M.D., and Franz J. Kallmann, M.D., with the assistance of W. Edwards Deming. Department of Medical Genetics, New York State Psychiatric Institute, Columbia University, New York. 1963. 260 pp. Distributed upon request; mailing charge $1.

The pronounced lack of knowledge among the deaf about the workings of heredity emerges from the mass of facts presented in this book by an interdisciplinary fact-finding team that ventured during 1955–62 into the family and mental health problems of the deaf in quest of a design for a dynamic, integrated guidance program. The three-pronged project—in research, psychiatric guidance, and guidance workers training—was conducted at the Department of Medical Genetics, New York State Psychiatric Institute, Columbia University, with the support of the U.S. Office of Vocational Rehabilitation (now the Vocational Rehabilitation Administration).

It was carried out by staff in clinical, social, and genetic psychology, audiometry, cytogenetics, psychology, and population statistics. Their findings, based on a study of persons over 15 years of age deaf from birth or early childhood in New York State and deaf twins in the eastern part of the United States, make up the bulk of the book's 19 chapters.

Among the many findings were: that nearly 10 percent of all children born to the deaf subjects are themselves deaf; about 15 percent of the congenitally deaf say they prefer to have children with normal hearing, yet they are apt to choose deaf mates; deaf children diagnosed as neurotic mostly came from families without other deaf members.

The fourth part of the book sums up and recommends, among other things, specialized psychiatric treatment facilities, properly integrated sex education throughout the school years, and individualized guidance to meet disordered behavior in the deaf; and careful community research planning, self-critical service, and training new personnel to prevent such behavior.

HOSPITALS AND CHILDREN. Edited by James Robertson. International Universities Press, New York. 1963. 159 pp. $4.

A 2-year-old in a hospital children's ward clings "like a little animal" to his parents, monotonous hopeless sobs change to piercing screams as his parents prepare to leave; a little girl sobs "Mummy, mummy"; and other children thus "suffer in a way that should make our civilized society ashamed of its cruelty." These are some of the images conjured in this book's 12 chapters of documented argument against separating young children briefly hospitalized from their mothers.

The book is constructed out of letters on hospital practices and attitudes from British parents who had children in hospitals. The letters are threaded together with a running commentary by the author, of the Tavistock Child Development Unit, London. They report on mothers' experiences of rooming in with their hospitalized children, unrestricted visiting, restricted visiting and associated difficulties, staff attitudes, and children's reactions after return home. In a concluding chapter called "A Blind Spot of Our Time," the author comments on the importance of implementing the recommendations of the Platt Report of 1959, described as having demonstrated the seriousness of separating the young hospitalized child from his parents.

WORKING WITH CHILDREN IN HOSPITALS: a guide for the professional team. Emma N. Plank, with the assistance of Marlene A. Ritchie. The Press of Western Reserve University, Cleveland, Ohio. 1962. 86 pp. $3.50.

Blending some principles of child development with lessons learned while operating a child-care program in the pediatric ward of a general hospital, the author has compiled this guide for persons working with children in hospitals. Beginning with the children's psychological state on entering the hospital, the book discusses spontaneous interactions and withdrawal among hospitalized children, ways of preparing children for surgery and helping them to work through their feelings afterwards, psychological handling of death on the ward, and play and learning activities in the hospital. Appendices include a "Letter to Blackie," an illustrated pamphlet that helps prepare children for surgery.

WORKING MOTHERS AND THEIR CHILDREN: a study for the Council for Children's Welfare. Simon Yudkin and Anthea Holme. Michael Joseph Ltd., London, England. 1963. 199 pp. 21 shillings.

In this profile of the working mother in Britain and her children—the product of discussions and research in which a number of British universities took part—the authors attempt to illumine a corner of life toward which they contend prejudice rather than fact has shaped public attitudes.

The book's eight chapters examine trends that have led mothers to take jobs, the attitudes of employers and the mothers themselves, arrangements for the children's care, and the effects of mothers' working on their children's growth.

According to the authors, working mothers of children 15 years of age and under make up one-quarter of the women in Britain's labor force and are essential to the economy.

The vast majority of mothers of preschool children make arrangements for child care that are adequate, claim the authors, who exhort officialdom, however, to consider the need for substitute care of preschool children of mothers forced to work and thus possibly forced to accept inadequate child care; and for comprehensive planning for older children to occupy them after school and during holidays.

Also noted is that the mother's working may in some instances mean a healthier family life, especially if the work replaces the father's excessive overtime. The authors urge more research about mothers who are sole supporters; industrial shifts to suit working mothers; and more practical help rather than criticism from educators, health visitors, and social workers, to mothers contemplating work.

BIRTH TO MATURITY: a study in psychological development. Jerome Kagan and Howard A. Moss. John Wiley & Sons, New York. 1962. 381 pp. $8.50.

Studying this report of a 30-year longitudinal study of stability of behavior are what the authors call "tentative bits of evidence" linking behavior in childhood with personality and interests later in adulthood. The authors, both research psychologists, studied 89 persons intensively from birth to 14 years and periodically thereafter, ending with a personality assessment of 71 subjects as adults.

After outlining their methods of assessing the adults for conceptual styles and intellectual functioning and examining the results against the data on these individuals as children, the authors identify islands of continuity in passivity and dependency; aggression, competitiveness, achievement, and recognition; heterosexuality; and social interaction. They also examine the effects of maternal practices on the child's development and other sources of conflict and anxiety.

In psychological tests reactions of the heart or the palm and interpretation of an ink blot are subject to complex processing and censoring by the individual and are thus no shortcuts to direct assessment of motive or anxiety, the authors maintain.

Guides and Reports

YOUTH TAKES THE FIELD. Committee on Youth Services, National Social Welfare Assembly, 345 East 46th Street, New York 17. 1962. 16 pp. 30 cents a single copy; 25 cents on orders of 25 or more.

Addressed primarily to youth 15 to 19 years of age, this booklet suggests ways to participate in community activities and records the priorities for action recommended by the youth delegates at the 1960 White House Conference on Children and Youth.

MEDICAL RESPONSIBILITIES FOR THE DISPLACED CHILD: report of the 43d Ross Conference on Pediatric Research. Charles D. May, M.D., editor. Ross Laboratories, Columbus 16, Ohio. 1963. 67 pp. Limited quantity free on request from Ross Laboratories.

These 13 papers presented at a 2-day conference held in June 1962 under the auspices of the New York City Department of Health and the Department of Pediatrics, New York University School of Medicine, emphasize the medical needs of children from families disrupted by illness, separation, death, or divorce, children of migrant workers, children in public welfare programs, and children in times of war or natural disaster.

NEED A LIFT? To educational opportunities. (12th edition, revised Fall 1962.) The American Legion Education and Scholarship Program, Americanism Division, Post Office Box 1055, Indianapolis 6, Ind. 1962. 100 pp. 25 cents. Copies available from The American Legion.

This annually revised handbook, published as a part of The American Legion's Education and Scholarship Program, contains sources of career and scholarship information for young people, including information on State laws that are offering educational benefits.

THE NEGRO AND EMPLOYMENT OPPORTUNITIES IN THE SOUTH. 1. A report based on a survey by Art Gallaher, Jr., Department of Sociology and Anthropology, University of Houston. Houston Council on Human Relations, 3605 Fannin Street, Houston, Tex., and the Southern Regional Council, 5 Forsyth Street NW, Atlanta, Ga., November 1961. 22 pp. 2. A report based on a survey by the Chattanooga Council for Cooperative Action, Major J. Jones, Research Coordinator. The Chattanooga Council, 601 East Ninth Street, Chattanooga, Tenn.; and the Southern Regional Council. February 1962. 16 pp. Publications free upon request from the local councils and the Southern Regional Council.

The first two of a projected series of employment studies in southern cities, these publications report on employment discrimination against Negroes in Houston and Chattanooga, showing that discrimination begins for the Negro youth long before he applies for his first job, because of unequal education and training in segregated schools.

HERE AND THERE

Freedom From Hunger

At midpoint in its 3-year-old Freedom From Hunger Campaign (see CHILDREN, March–April 1963, p. 83), the Food and Agriculture Organization of the United Nations (FAO) sponsored the World Food Congress in Washington, D.C., during 2 weeks this past June. About 1,100 delegates from more than a hundred countries attended the Congress, where they exchanged information and ideas on world food problems—notably the race between soil fertility and human fertility.

Problems associated with this race dominated the plenary sessions: Dr. B. R. Sen, director-general of FAO, estimated that to meet the minimum food requirements of developing countries by the year 2000, food output there would have to be augmented three or fourfold; United Nations Secretary-General U Thant pointed out that increasing the food supplies of these countries must be paralleled by stimulating the economy to augment the people's purchasing power for buying nutritious food; and the British historian Arnold J. Toynbee called on all nations to act as "a single world-wide unit" for producing and distributing food and for voluntary regulation by families of the birth rate to match "the already achieved reduction of the death rate," and warned that science cannot increase the food supply ad infinitum.

Dr. Candau, director-general of the World Health Organization, observed that, for the most part, malnutrition underlies the high death rate of children under 5 in some areas of the world, a fact he said was not reflected in mortality statistics since death certificates show the killing disease or ultimate condition invited by malnutrition but not this basic cause.

Other speakers made these points:

- While the regions now most deficient in food are where future populations are likely to be greatest, the world's land and resources are ample for future populations until the end of the century if properly used.
- Illiteracy among farmers and impractical, nonfarm-oriented education of farm youth in some areas of the world hinder improvement in farm methods.
- Rather than donations of surplus foods, developing countries need to have the knowledge, techniques, and tools that made those surpluses possible.
- The efficient and substantial growth of livestock industries in developing countries is hindered by insufficient demand for meats because of low per capita incomes.
- In advanced countries, food faddism, diet neurosis, and superstitions about food can lead to bad nutrition.
- Governments ought to set up units to advise people on nutrition and good eating habits.

Out of the discussions that took place in several technical work groups of the Congress emerged recommendations that governments keep in mind that good nutrition is essential for the health and well-being of their populations, and that they base their policies on the recognition that food is a means to health, efficiency, and well-being rather than "some edible stuff that temporarily suspends the agonizing qualms of hunger." Also proposed was that supplementary feeding programs for children planned by governments be more clearly defined as to targets and geared to local conditions so that they reach those needing them but not now included.

Permeating both plenary meetings and discussions was a concept expressed in various ways: that freedom from hunger is man's fundamental right and that the persistence of hunger, malnutrition, and poverty—among more than half of mankind—is unacceptable morally and socially and is incompatible with the dignity of human beings.

—Eleonora Chatty

About Glue Sniffing

Concern over an apparent increase in the incidence of the intentional inhalation of plastic cement by children and teenagers has prompted the Children's Bureau to gather available information on this practice, known as glue sniffing, and its effects on the young people who engage in it. The practice first came to public attention in 1959, and in the following 2 years had engendered sufficient concern to be mentioned at the White House Conference on Narcotic and Drug Abuse as a hazardous teenage fad necessitating a community education approach. It has received considerable attention in the news media and some in medical journals, the latter usually warning against arousing the curiosity of the young by giving this practice, believed to be a fad, too much publicity.

In an article in the *Journal of the American Medical Association* (July 28, 1962), Drs. Helen H. Glaser and Oliver N. Massengale have described the effects of glue sniffing as varying from a mild "jag" to drowsiness, stupor, or unconsciousness, and have reported that the practice sometimes leads to nausea, loss of weight, irritability, irritation of the mucous membranes of the nose and mouth, distorted vision, headache, and dizziness.

The toxic substances most commonly present in plastic cement are acetone and toluene. Other substances sometimes included are benzene, carbon tetrachloride, methyl ethyl ketone, amyl acetate, butyl acetate, ethyl acetate, and butyl, all solvents commonly used in paint products and not deemed toxic in proper use. Some manufacturers are endeavoring to develop a substitute for these toxic solvents. The Hobby Industry Association of America which estimates that 15 to 20 million young people enjoy plane construction is also testing for a nontoxic solvent.

Other efforts to control the practice thus far have included conferences between public health authorities and representatives of the glue manufacturing industry; in a few rare instances, specific legal restrictions either through city ordinance or State law to prohibit the practice; and vountary restriction of sales by merchants.

No reliable statistics on the total number of young persons indulging in glue sniffing are available, nor has any laboratory study been reported of any considerable groups of adolescents who engage in the practice. The one reported death associated with the practice in 1962 was of a 15-year-old boy who had placed a plastic bag containing the contents of a tube of glue over his head, and who may have died of suffocation rather than from the toxicity of the inhalant. However, a report of the National Clearing House for Poison Control Centers, Public Health Service (February–March 1962), reports that the liver, kidneys, bone marrow, and nervous system can be affected by the inhalation of volatile solvents.

—Alice B. Freer

Handicapped Children

The Speech Therapy and Audiology Departments of the Children's Hospital at Denver, Colo., report finding several consistent factors in the early developmental histories of the 2,000 children seen in the hospital's out-patient department for speech, hearing, or language disorders over the past 10 years. The histories, based on information given by the children's parents, revealed the following similarities in the infancy of these children:

1. They did not have strong cries.
2. They were too quiet and good, or they were very fussy and difficult to care for.
3. They drooled more and for a longer period of time than was normal.
4. They had difficulties with sucking and sometimes did not swallow easily.
5. They were not interested in noise-making toys.
6. They were less responsive to voices.
7. They were slow to laugh aloud, coo, and babble.
8. They were slow to attempt smiling.
9. They had digestive difficulties with numerous changes of formula.
10. They were slow in physical and visual responsiveness.

During the past 3 years the hospital's Speech Therapy and Audiology Departments have developed and tested a chart, called the Communicative Evaluation Chart, to help pediatricians and speech and hearing specialists make quick appraisals of a child's development of communication abilities from infancy to 5 years of age.

Mental Retardation

Between July 1, 1962, when a program to detect phenylketonuria in newborn infants by using the Guthrie blood drop test first began, and August 1, 1963, about 240,000 babies were screened for the disease and 24 cases were uncovered. The affected infants were placed on a diet calculated to lower the phenylalanine content of the blood and thus prevent mental retardation.

Present field trials of the Guthrie assay as a screening technique call for collection of 3 drops of blood from 400,000 infants before they leave the hospital and an evaluation of the assay as a screening tool. The program is being carried out under the auspices of State health departments in 29 States, and Puerto Rico with the cooperation of the Children's Bureau. (See CHILDREN, May–June 1962, p. 123).

Since 1956, the Bureau has been working with the State health departments in developing detection and followup diet programs as well as the needed laboratory facilities. As a result of screening activities from 1956 to 1961, mainly with the urine test, 484 children with phenylketonuria were detected and put under dietary supervision.

For Youth

This past spring saw the launching of a pilot project called "A Future for Jimmy," by the Urban League of Washington, D.C., to encourage positive attitudes toward education, life, society, and the future among the city's junior and senior high school students. The project is designed to reach particularly the student of average ability who has difficulties—often serious—and who is culturally deprived and not in trouble but would ordinarily get no help unless he were. Such students are estimated to comprise one-third to one-half of the cities secondary school population.

The project began operations in May with a school-centered phase, offering volunteer tutorial or remedial programs in a junior high school and five churches in the school area, which is characterized by low-income and low morale. Other activities scheduled during this phase included a back-to-school rally during August, counseling potential dropouts, career clinics, vocational guidance meetings, field trips for students to institutions of higher learning, and a "student-recognition day" at the local stadium. The project then proceeded to a home-centered phase—including a summer job program, to give "Jimmy's" family a financial "lift"—and then to a community-centered stage, to help these young people identify with their community and the community with these youth. This phase includes a program of assembly lectures and office visits that bring together students and community leaders who exemplify personal achievement.

The "Jimmy" project is directed by 3 professional workers, 2 social workers and a guidance counselor, aided by an advisory committee of 22 representatives of the social services, the schools, business, the press, the home, and Government. Also, students and faculty members of each participating school help in drawing up plans for the program.

Vaccines

A live virus oral vaccine that protects against all three types of polio was licensed by the Public Health Service in June. The license to produce the 3-in-1 vaccine, combining the three strains of the Sabin oral polio vaccine, was granted to Lederle Laboratories. According to the Service, the product gives some active immunity against all three types of polio after the first feeding and more protection after the second, final dose 8 weeks later.

The three monovalent oral vaccines, developed by Dr. Albert Sabin of the University of Cincinnati, call for one dose each a month apart of each strain to protect against each type of polio. The Salk, killed virus vaccine, also a polyvalent vaccine, calls for three doses, plus a booster shot after a year.

The new product, tested in accordance with Federal regulations, has been found to induce antibodies in at least 90 percent of those who completed the dose schedule.

Public Assistance

Nearly 95 percent of families in State programs of aid to families with dependent children were found eligible for aid under their States' laws and regulations, according to the findings, released in midsummer, from the nationwide review of eligibility conducted in the first 6 months of 1963 by the Bureau of Family Services, Department of Health, Education, and Welfare, in cooperation with the welfare departments of the 50 States. (See CHILDREN, January–February 1963, page 39.) However, wide variations in rates of ineligibility were found among the various States, the range running from no ineligibility (Montana and North Dakota) to 17 percent (West Virginia).

The average rate of ineligibility was 5.4 percent. States' definitions of eligibility vary according to their laws and regulations.

Wide variations were also found in rates of both over and underpayments to eligible families on the rolls. Those States with high rates of overpayments also had high rates of underpayments, the range in both types of errors running from slightly more than 42 percent of all eligible families to less than 1 percent.

Wide variations were also found among the States in average size of caseloads per worker, ranging from 222 cases in Alabama to 52 in New York State. In all but one instance (Oklahoma) those States which had average caseloads per worker of 100 or more had above average rates of ineligibility.

Average costs of administration per case per month were found to range from $27.25 in New York to $3.82 in Arizona. States with high or medium administrative costs ($12 to $14 a month) tended to be among those with low rates of ineligibility, while those with low administrative costs tended to have rates of ineligibility that were above average.

The findings on ineligibility showed that errors in agency practice accounted for larger proportions of ineligibility than intention on the part of recipients to misrepresent or conceal facts. In eight States no cases of intentional misrepresentation were found among the recipients of aid. In only eight States did intentional misrepresentation run higher than 3 percent of the total caseload.

In submitting the report of the findings to a subcommittee of the Senate Appropriations Committee on July 30, Secretary of Health, Education, and Welfare Anthony J. Celebrezze pointed out that because of the weaknesses in policies and procedures found in some States the Department is requiring the States to initiate the following remedial actions: (1) redetermination of eligibility of each case every 6 months, effective July 1, 1963; (2) reinvestigation, including home visits, of a sample of cases each month starting September 1; (3) undertaking intensive reviews with staff of the Department of Health, Education, and Welfare of the States' administration of the program to correct problems brought out by the eligibility study.

The study, which was carried out on the request of the Senate Appropriations Committee, covered 2 percent of the total AFDC caseload, including cross sections of the caseloads of all 50 of the States. It involved a staff of 104 Federal persons from the Department of Health, Education, and Welfare and 2,403 persons from the States.

The study was observed simultaneously by the U.S. General Accounting Office which is issuing a separate report.

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The average annual income per person in households receiving aid to families with dependent children during December 1961 was roughly $408, including the public assistance grant, according to a survey conducted that month by the Bureau of Family Services, U.S. Department of Health, Education, and Welfare, the preliminary findings of which were released last spring. The annual per capita income in 1961 for the United States as a whole was $2,263.

The survey focused on characteristics and financial status of the 910,000 families, including 2,733,000 children who were receiving AFDC payments. Information was gathered on income, educational background, occupational history, parental incapacity, and the legitimacy of the children.

Some other of its findings were:

- The average AFDC family consisted of four persons with an average budgeted need, as determined by the individual States, of $158 per month, or $1.35 per person per day. For all AFDC families in the study month, the average income was $139.78 per month, the gap between State-defined budgeted needs and total resources per family averaging nearly $18 a month. About 45 percent of the families studied were reported to have needs unmet by any income source, the gap between needs and resources in these families averaging $40 a month.
- In 13 percent of all families on the AFDC rolls, the mothers worked, earning an average of $54 a month.
- In the big cities, 63 out of every 1,000 children under 18 were in the AFDC program; in farm areas, 26 per 1,000; and in the suburbs, 17 per 1,000.
- Half of the families lived in crowded conditions (more than 1 person per room); and one-fourth in seriously crowded conditions (averaging more than 1.5 persons per room).
- Of all children in the United States known to have been born out of wedlock, an estimated 21 percent were receiving AFDC assistance, but only about 15 percent needed assistance because of their birth status. The remaining 6 percent were in need because of the death, incapacity, or unemployment of the father or stepfather.
- More than three-fourths of all children on the AFDC rolls during the study period had been born in wedlock.
- More than one-third of the mothers on the AFDC rolls had not completed elementary school; only 16 percent had finished high school.
- The median length of time the families had been on the AFDC rolls was 2.1 years.

Abused Children

The Children's Bureau has drafted and is now distributing suggested language for a State law to protect the physically abused child. Calling for mandatory reporting by physicians and institutions to police authorities of physical abuse of children based on medical findings, the proposed law appears as the fourth of a series of legislative guides prepared by the Bureau to help the States develop sound legislation for the welfare of children.

The new guide grew out of two all-day conferences of lawyers, judges, physicians, social workers, and other specialists that were called by the Children's Bureau during 1962 in response to reports of increasing physical abuse of infants and young children by parents or other caretakers. (See CHILDREN, May–June 1962, p. 123, and September–October 1962, pp. 200–201.) Following through on a recommendation of these groups, the Bureau assembled a small body of technicians to draft suggested legislative wording for use by the States.

In addition to the proposed law, the new guide contains a discussion of the principles behind it. The guide points out that the primary responsibility for meeting children's needs rests with the parents, and that society is obliged to assume this responsibility when parents cannot. Observing that the physician is in an optimum position to form reasonable, preliminary judgments as to how a child's injuries occurred and that when he finds conditions in which physical abuse (as defined in the proposed law) is a likelihood, neither he nor an institution in which he serves is required to have any discretion in the matter of notifying the appropriate police authority. The proposed law is presented as a first step in protection which should lead to further steps by the community to provide the child with a wholesome environment.

The model law provides for immunity from liability, civil or criminal, for the person or institution reporting; and for nonrecognition in instances of such abuse of the usual physician-patient or husband-wife privilege as grounds for excluding evidence; and makes willful violation of the law's provisions a misdemeanor.

Unmarried Motherhood

Blurred or faulty communication lines among the health and social services and schools were named as a common problem in services to unmarried mothers, during a series of meetings on unmarried motherhood held in five cities and attended by representatives of health and social services, on invitation of Children's Bureau representatives of Region IX. The meetings took place in San Francisco, Honolulu, Portland, Oreg., Los Angeles, and Phoenix—the first meeting during November 1962, and the last in March 1963—metropolitan areas which show increases in general population and in unmarried mothers without comparable expansion of services to meet the latters' needs. The participants—a total of 145 at the meetings—included representatives of public and private adoption services, maternity homes, multiple service social agencies, health departments, hospitals, visiting nurse associations, and other health services, school systems, probation departments, and schools of social work.

Some of the blocks to improved services identified at the meetings involved: the problem of the rights of parent versus rights of the child; disagreement on the agency role in accepting voluntary surrender of the child from the mother; variations in the ways minor unmarried mothers are encouraged to exercise their rights to consent to adoption; residence requirements and other restrictions on eligibilty for service, particularly for financial assistance and medical care; and the inhibiting effect on planning of the lack of information on unmarried motherhood—a lack attributed mostly to agency compliance with these mothers' need for anonymity.

Most of the proposals for action that came out of the sessions centered on research and experimentation: in the causes of illegitimacy and ways of reaching unmarried mothers early in pregnancy; on experimental adoptive placements of children from minority groups with persons of other races, and of seriously handicapped children; on services to unmarried fathers. Still other proposals were related to planning for full use of Federal and State resources in the fields of family services, health, mental health, corrections, and welfare; the availability of Federal funds for program development by private agencies; the possibility of carrying out workshops or other projects for development of staff to work with unmarried mothers.

Research

A study has been launched in Prince Edward County, Va.—where public schools were shut down 4 years ago to avoid court ordered racial desegregation—by a research team from Michigan State University to determine the effects of the public school closure on children thus deprived of schooling. The project, which began last spring and will continue through the end of June 1964 under a contract carrying a $75,372 grant from the U.S. Office of Education, is being carried out primarily by graduate students in psychology.

Correction

A footnote mistakenly appeared on page 147 of the July–August 1963 issue of CHILDREN accompanying the article by Marguerite Q. Grant and Martin Warren. The footnote, which referred to a project supported by the Vocational Rehabilitation Administration, correctly reappears in this issue accompanying the article on hemophiliacs on page 189.

READERS' EXCHANGE

CHILMAN AND KRAFT, AND HILL:

What about the fathers?

I was interested to note that in their article, "Helping Low-Income Parents: I. Through Parent Education Groups" [CHILDREN, July–August 1963], Catherine Chilman and Ivor Kraft discuss only briefly the environmental conditions of life of low-income parents. This is probably as it should be, for I believe efforts to help such families have been hindered as much by stereotyped predispositions as by insufficient information about the lower class. The authors wisely counseled parent educators to learn directly from low-income family members what is important to them—in other words, to accept the low-income mother as a person before attempting to change her behavior.

I was glad to see the authors gently lay to rest arguments about which academic discipline is best, and to find that they were unconcerned about the social class origin of persons who teach in parent education so long as they are flexible, perceptive, and competent.

In general, the discussion by Drs. Chilman and Kraft revolves around three themes: (1) low-income parents are a withdrawn people to whom one must reach out more than halfway; (2) low-income parents are an unsure people who must be taught, shown, and supported in specific and concrete ways; (3) low-income parents are a diversified people who must be reached through a variety of approaches. But probably its most significant contribution is its strong emphasis on *how* these things are being done.

Director M. Esther Hill of the home economics education division in the Philadelphia schools presents an excellent illustration of how these themes have been structured into an ongoing program in a specific locality. ["Helping Low-Income Parents: II. Through Homemaking Consultants."]

As exciting as the programs described in these articles are, one still wishes that methods had been found to reach fathers in the families. In Philadelphia, for example, fathers were present in two-thirds of the families referred to the service, but there was no mention in Miss Hill's article of any contact being made with them. Similarly, after talking with more than 60 persons associated with parent education projects throughout the Nation, Drs. Chilman and Kraft could only report that "experimentation to find ways of reaching fathers is under way in some agencies."

Let us hope for articles on how to help the low-income father.

Dr. Charles V. Willie
Research Director, Washington Action for Youth, Washington, D.C.

Similarities in parents' groups

The two articles which appeared in the July–August 1963 issue of CHILDREN under the title "Helping Low-Income Parents" provide an occasion for us to reexamine a number of issues involved in serving disadvantaged families by means of education for child rearing and homemaking.

One of the first issues raised in the article by Drs. Chilman and Kraft is the social class bias which some people believe has characterized family life education. While the Children's Bureau survey they describe failed to uncover many educational programs, per se, for low income parents, it should be remembered that a very significant form of parent and homemaking education has been provided such families by public health nurses and staff members attached to the community health centers many of these families frequent. The criticism that "the people who need it the most don't get it" is more appropriately leveled within than between groups. If we permit the mistaken idea that people in disadvantageously social and economic situations are unacquainted with educational efforts aimed at improving the "physical, emotional, social, and economic life of the family," we are in danger of jeopardizing future educational endeavors by instilling inappropriate expectancies in persons being trained for this work.

Not only has work already done with inner-city, low-income families revealed substantial eagerness to learn, but also an essential similarity of interests with regard to education for child rearing. About 2 years ago we compared the expressed child-rearing interests of a large group of suburban middle-class parents with those of a very low-income, poorly educated group of parents living in the city slums. Virtually no differences were found between the two groups in ranks assigned to the 10 most popular topics. Therefore, it seems inappropriate to emphasize the differences between the concerns of parents who represent varying social, educational, and economic levels. Rather, we can intensify our educational work fortified by the fact that our message is a relevant one.

We would also underscore the fact that the mark of a good program is *not* the size of the audience, and that those parents who resist all efforts to involve them in a group educational experience and whose neighbors describe them as desperately in need of this kind of help are probably incapable of profiting from a program of this sort. For such parents we must continue to provide help on an individual basis. It is essential that those who would provide education for child rearing and homemaking appreciate the remarkable opportunities which await them while recognizing the distinct limitations which are a function of the methods they must employ.

Armin Grams
Head, Parent Education Program, Merrill-Palmer Institute of Human Development and Family Life, Detroit, Mich.

DRUGS AND ACCIDENTS

The statistics on childhood accidents on page 245 of the November–December 1962 issue of CHILDREN lead me to call attention to a question of some concern. How important is the role of maternal drug intoxication in accidental death and injury of infants and young children in and around the home? When I recently broached the subject to a group of pediatricians, they did not know of any research on the subject and agreed it was an important one for investigation.

I have direct and indirect knowledge of several examples. In one instance, the mother under the influence of 4½ to 6 grains of Seconal dropped a baby, fortunately with no serious result. At the hospital the family physician, diagnosing the mother's condition as emotional shock attributable to the child's accident, gave her a drink of whisky.

If I were to estimate the relative importance of intoxicants in such accidents, I would place alcohol first; then in descending order, tranquilizers, barbiturates, and narcotics. "Addictive doses" of these drugs are hardly necessary to produce the little impairment of coordination and judgment that result in an otherwise avoidable accident at home or behind the steering wheel.

Admittedly, diagnosis of the drugged mother's condition after such an accident is difficult because of her obvious emotional reactions to the child's injury. But it is more likely if the physician is alert to the possibilities. If habitual or addictive use of drugs was established, the mother might be induced to accept psychiatric treatment for her underlying personality problems. Her guilt feelings about the accident could be used to overcome resistance to treatment.

I would like to see a psychiatric multidisciplinary research team provide 24-hour-a-day coverage of the emergency services of a large hospital for several months. Everybody involved in every accident would be studied as thoroughly as possible on the spot. Followup would be provided as indicated. Such research obviously could supply answers to many questions about accidents.

H. Robert Blank, M.D.
Associate Clinical Professor of Psychiatry, Albert Einstein College of Medicine, New York

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For Parents

DIAGNOSIS: EPILEPSY; a guide for parents. Jacqueline T. Leonhard. Parents Committee on Epilepsy, Family Health Association, Cleveland, Ohio. 1962. 39 pp. 50 cents.

THE GREATEST ROLE IN THE WORLD. Prudence Hamilton. Vantage Press, New York. 1962. 107 pp. $2.95.

Written for mothers, by a mother, with emphasis on the child's psychic health and well-being.

PARENTS ASK. Frances L. Ilg and Louise Bates Ames. Harper & Bros., New York. 1962. 425 pp. $5.50.

Based on suggestions offered in reply to letters received during the past 10 years from parents seeking advice concerning behavior problems in children under 10.

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SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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INFANT CARE. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 8. 1963. 108 pp. 20 cents.

Addressed to parents, this 11th and entirely new edition of the Children's Bureau's bestseller since 1914 presents up-to-date information on the care of infants from birth to 12 months. It was prepared with the help of nearly 100 persons including specialists in the fields of psychiatry, psychology, pediatrics, orthopedics, nutrition, and parent education.

Appendices include among other items discussions of: special problems, such as care of the premature or handicapped infant; preventing disease and accidents; the care of the sick baby; infant diseases and disorders; and emergencies.

PRENATAL CARE. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 4. 1962. 92 pp. 20 cents.

This 5th edition of the Bureau's publication for expectant parents, including fathers—first issued in 1913 and last in 1949—presents information on the physical and emotional changes that take place during pregnancy and childbirth and offers advice on the care of the mother and preparation for the newborn. Throughout it stresses the importance of medical care during pregnancy and of including each family member in the preparations for the new arrival.

CREATING EXPERIENCE OPPORTUNITIES FOR YOUTH—to achieve a more responsible role in society for self and social identity for realizing American goals. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. 1962. 102 pp. Single copies available from the Bureau without charge.

This is a report of the Joint Conference on Children and Youth, held in Washington, D.C., April 10–12, 1962, sponsored by the National Committee for Children and Youth, the Council of National Organizations for Children and Youth, the National Council of State Committees for Children and Youth, and the Federal Interdepartmental Committee on Children and Youth as followup of the 1960 White House Conference. (See CHILDREN, July–August 1962, p. 163.)

It presents summaries of the major speeches and roundtable discussions and extractions from reports of the national organizations concerning their respective programs since 1960. Appendices include the conference program, a brief description of the conference planning, and summaries of the biennial meeting of the Council of National Organizations and of the annual meeting of the National Council of State Committees.

INSTITUTIONS SERVING DELINQUENT CHILDREN; guides and goals. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 360. Revised 1962. 141 pp. 45 cents.

A revision of a 1957 document prepared in cooperation with the National Association of Training Schools and Juvenile Agencies for the staffs of institutions for delinquent children and other agencies and officials in the correctional field, this publication discusses the philosphy of institutional administration; the physical plant; and the major aspects of the treatment program, including individualized services, special institutional problems, and preparation for the child's return to the community and aftercare supervision.

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Psychiatry in a Pediatric Ward

Casework for Abused Children

Halfway Houses for Delinquents

Working Mothers' Expenses

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◀

TWO HOSPITALIZED CHILDREN in the pediatric ward of a large municipal hospital. How a psychiatric consultation service within such a hospital works with the ward staff as well as directly with the children to mitigate the emotional stress which often interferes with children's recovery is described in pages 207–212.

◄ *the authors*

To her present chair on the Boston University medical faculty, which she assumed in 1959, Eleanor Pavenstedt brought a background of experience in child psychiatry, psychoanalysis, and pediatrics in Massachusetts hospitals, private practice, agency consultation, teaching, and research. In her present research, she is focusing on the effects of maternal maturity level on child development. Her training, begun in Geneva, took her to London, New York, Baltimore, and Boston.

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With graduate training in both home economics and social work, Luise K. Addiss has spent her professional career in voluntary family service agencies, 3 years as caseworker and the rest as home economics consultant. She has also been part-time instructor of family economics—in which she obtained her master's degree—at the New York School of Social Work. She has been with the Community Service Society for the past 10 years.

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Psychiatric consultants and pediatric staff have a mutual learning experience when there is . . .

A CHILD GUIDANCE SERVICE IN A MUNICIPAL HOSPITAL

ELEANOR PAVENSTEDT, M.D.

Professor of Child Psychiatry
Boston University School of Medicine

ANYONE who has worked in a municipal hospital has been struck by the particular pace and atmosphere that prevail and differentiate it from all other hospitals. There are vivid contrasts between the dimly lit corridors with their peeling walls and endless pipes and the clusters of alert, active young men and women who hurry down them. The nurses and young doctors are there to receive training and the broad experience and greater responsibility such an institution provides. In their alertness they form a sharp contrast to the apathetic indigent patients who seldom complain about having to wait all morning for a rapid examination and a minimum of communication, and who often leave with little understanding of what ails them, clutching their prescriptions and hoping the corner druggist will add still another item to their debt.

Some patients even seem to find the dreary waiting rooms a haven where they can sit for a few hours with only one or two children tugging at them, without dirty laundry demanding to be washed or four blank walls reminding them of the isolation of old age. They are surrounded by companions in misery, in physical touch with other humans who make no claim on them. Perhaps they experience a certain comfort in knowing that their bodies will receive care. The city hospital provides them with the same sort of parsimonious (not begrudging but measured) care that the over-burdened mother of a large family gives her offspring. Many of them feel alien and hostile toward the community at large, which has seemed to shunt them aside. They feel rejected often even by their churches, are fearful of law enforcement agencies, and are resentful of the inquiries made by public welfare investigations. They trust the hospital personnel, however, who treat them without questioning their way of life and allow them to maintain their privacy.

On the other hand, among large numbers of these patients the normal anxiety that most patients feel in hospitals is augmented by a cultural communication handicap. Having very limited vocabularies, they do not feel comfortable with words. Few doctors talk to them in a language they can understand. For example, a nurse who often accompanies patients of the family-care program of the Boston University School of Medicine to the outpatient clinics of the city hospital has found that the patient is often too abashed to give a correct history or to make his complaints clear; completely fails to understand what the doctor says; and because of the technical terms he uses usually leaves the clinic with ominous forebodings, unclear about the directions for further treatment and care.

Psychiatrists, when they first come to work in such an institution, long to change many things, to humanize administrative and medical procedures, and to personalize the contacts of the medical and paramedical staff with their patients. They find, however, that they can make headway only very slowly against practices that have over the decades become acceptable to both patients and personnel. A city hospital is no place for a psychiatrist who rushes in with evangelical zeal, nor for one who closes his eyes to situations that are psychologically painful for him to see. However, the psychiatric consultant in a city hospital who realizes that change is apt to come as gradually in colleagues as in patients will reap many rewards in terms of professional growth, for himself as well as for the young medical and paramedical staff. And this, of course, will accrue to the benefit of the patients.

The child psychiatrist usually finds his way into a municipal hospital through the pediatric service, which has asked him to serve as consultant. He will do well to use some of his time in the beginning, before he becomes burdened with many requests for consultation, in becoming acquainted with the nurses, the aides, and the technicians, and to familiarize himself with the emotional climate on the wards, the nursing care, and the medical, particularly the admissions, procedures. In a busy city hospital, he may be struck by the friendly attitude of the nurses, which contrasts with the often dismal appearance of the ward, the absence of toys, and the physical restraints imposed on the children. He will find children being fed, often distasteful diets, by well-meaning, but usually not well-trained, aides. He will find television programs—about marital discord in upper-class homes, shootings, and accidents—drowning out the sound of a child's crying. He will find some children sitting around in obvious despair, impassive withdrawal, or fear; others playing comfortably with each other; others talking compulsively or running about in a hypomanic state.[1] This is a time for silent note-taking on what needs to be changed.

Children at play in a hospital ward. Observations of what hospitalized children do and say while playing or in a group discussion can provide many clues to their inner feelings.

Requests for Consultation

Many nurses will engage the consultant in conversation as he goes through the wards, voicing their concern about a patient who has not been officially referred to his attention. Such discussions had best be kept at the level of management of the child, which is the nurse's particular responsibility. A helpful clarification of underlying anxiety or depression may win over a faithful helper.

The importance of the psychiatric consultant's making himself available to the pediatricians whenever the need for him arises cannot be exaggerated. Unless the psychiatrist sets aside a sufficient number of hours for this function, upon which pressures for service to psychiatric patients are not allowed to infringe, communication with pediatric colleagues will be slow in developing.

Informal meetings are also valuable. In the Boston City Hospital, the box in which consultation requests are deposited is outside the doctor's dining room. This facilitates informal communication between the consultant and the pediatrician at mealtime. The pediatrician is encouraged to tell the consultant what observations he has made that have led him to be concerned. Often these observations are much more astute than child psychiatrists give other physicians credit for being able to make.

One of the psychiatric fellows at the Boston City Hospital, who was formerly a pediatrician, has noted that the pediatricians know much more about their patients than they put into their notes or even into the record, and that their reason for requesting a psychiatric consultation is not by any means completely revealed by, nor does it sometimes even correspond to, the written request.

The psychiatric consultant may be called in on a case because of a child's failure to improve physically after the acute phase of his illness is over, or because the medical staff wants his advice concerning the timing of an operation or the wisdom of plastic repair work or about whether a hermaphrodite should be directed toward feminine development even though the internal female organs are missing.

The psychiatric consultant will also frequently be called upon to support children reacting to acute stress, particularly when orthopedic, genito-urinary, or cardiac surgery is involved. The hospital provides him with an excellent opportunity to study children reacting to severe traumata and to see them recovering their emotional equilibrium through a whole series of defense mechanisms. He will support the child's efforts to achieve this equilibrium and sometimes by his awareness of what is going on will be able to swing things in the direction of greater maturity. He will principally stand by, for it would be foolhardy to intervene in the child's struggle.

Tragic cases come to a city hospital: a 7-year-old assaulted by her mother's lover in the hallway of a housing project, to whom a benevolent group sends, of all things, a large bride doll; a 6-year-old with a gunshot wound, who survived her father, who succeeded in killing himself and her brother; a 5-year-old boy who started a fire in which his baby brother was smothered. The opportunity of observing and assisting children in such acute crises is a rare experience for child psychiatrists, who in child guidance clinics or in private practice usually do not see children until many months after a traumatic occurrence. All degrees of deprivation and its effect on the child's response to people and toys can also be seen.

Dealing With the Child

In the city hospital the psychiatric consultant will be dealing with a child who is separated from family and home and often in pain or discomfort. Frequently his interview with the child will have to take place at the bedside with a semicircle of curious little wardmates offering their comments. The child may be uneasy or suspicious of him, a new character in the hospital's procession of strange adults. The diagnostic process is not easy to carry out under these circumstances.

Some child psychiatrists depend on their conversation with the patient and on observations of his behavior and of his interplay with the other children, and may use the patient's own playthings to elicit feelings and fantasies. Others come equipped with a box of small therapy toys. If the hospital has a social group work program, the psychiatrist may obtain considerable information from the group worker concerning the patient's relationships with his peers, with the group worker, and often with visiting parents, as well as about the patient's feelings, conflicts and fantasies, his attempts at mastering his anxiety, and his ideas concerning his illness, his treatment, his doctor, and his nurses.

For example, at the Boston City Hospital, the social group work staff arrange to see a child as soon as possible after admission to allow him to express some of his concerns and to provide him with appropriate activities until he can join their play group. Many isolated or withdrawn children are helped to overcome their timidity and suspicion and learn about the pleasures of social contacts for the first time through this program. By the time the psychiatrist is called in on a consultation, much useful information has been amassed by this staff, which greatly facilitates diagnosis and planning.

As requests for consultations begin to come in, the consultant is confronted with the problem of who is to interview the child's parents. If the psychiatrist himself performs this task, it will be easier for the pediatrician to accept its importance and meaningfulness. However, parents' visits to their children, especially in a city hospital, are often irregular. Many parents are hard to reach and unreliable in keeping appointments. The psychiatric social worker on the hospital staff is apt to have more flexibility in regard to commitments and is well equipped to work with parents.

Some pediatricians will feel less threatened by the status of a social worker than of a psychiatrist so that they may learn more freely from her. The drawback to this as a learning experience useful to them in the future is that the pediatricians are not likely to have a social worker available to them when they are in private practice. Nurses who have had, or who are taking, postgraduate training in mental health nursing are more and more frequently working on pediatric wards and may be called upon to make a home visit and obtain the information the psychiatrist needs. They will be more familiar as working colleagues to most young pediatricians, and they may be more accessible to these physicians later in their private practice.

The psychologist is also a source of information about the child, and the psychiatric consultant may request a test or a battery of tests—always remembering that test results are of relative value only, particularly when the child tested is a hospitalized child.

A city hospital, where small children are "dumped" over every long weekend, and where many parents do not appear to pick up their children upon recovery, offers the professional person a splendid opportunity to observe all the early stages of development. The clinical psychologist can be of great assistance here in demonstrating different stages of growth, with the constant reminder that children do not perform to capacity during hospitalization. For example, on the orthopedic and surgical wards, enforced immobility will have serious and demonstrable effects on 2- and 3-year olds. Some children with chronic conditions and prolonged or repeated hospitalization will show too ready contacts, with rapid shifts from one person to the next, or apathy and listlessness. The importance of assigning the care of babies and very young children each to one special person cannot be too strongly stressed.

Psychiatrist and Pediatrician

The psychiatrist will do well to learn from his pediatric colleagues the difference in behavior of sick and well children of various ages. Pediatricians possess a wealth of information invaluable to the child psychiatrist concerning daily fluctuations in children of mood, alertness, responsiveness, fatigue, and hunger.

Because of the difference in pace and approach between psychiatrist and pediatrician, the latter's necessarily being more direct and factual, the pediatrician is apt to be impatient with the psychiatrist's reluctance to make a diagnosis and to make a recommendation before he has all the necessary information. For this reason, the consultant will do well to share his observations and findings with the pediatrician as he goes along, making it clear that he is withholding his final judgment.

In some instances when pediatricians make a diagnosis of psychogenicity of a child's condition after they have excluded the possibility of tissue alteration, cell chemistry, or of organ functions being involved, the psychiatrist may rule out psychological causes because the presenting picture deviates so much from familiar psychological symptoms and because the child's behavior is not compatible with an emotional disturbance.

Probably the greatest difference between the approaches of pediatricians and psychiatrists is in problems of "habit training." Soiling, or encopresis, in a child in the latency stage (6 to 10 years old) is a typical example of a case that presents mutual frustrations. Before the psychiatrist is consulted, habit training has usually been instituted. The background for this symptom is usually difficult to establish and not infrequently involves a serious family problem that is guarded with great secrecy. Since the psychiatrist has little to offer in the way of etiology or dynamics, the pediatric service continues its habit training. Quite often the child, temporarily removed from the source of his conflict, conforms and is sent home "cured." Only with the third hospitalization for recurrence is the child finally sent to treatment in the child guidance clinic. By the time the etiology has been established and a change has been brought about, the pediatric interns and residents who were on the case have departed from the hospital.

In contrast, the same problem in a preschool child, when the onset is recent and precipitated by a specific event, often lends itself exceptionally well to short-term play therapy by a psychologically gifted pediatrician.

The management of a child who refuses to cooperate in the regime outlined for him by the pediatrician is sometimes a source of difficulty between the psychiatrist and the ward staff. Too often the psychiatrist is not called in on such a case until the doctors and nurses are at "their wits' end." By this time several approaches to the problem have been tried unsuccessfully and feelings run high. If the psychiatrist attempts to give an explanation of the child's problem based on theories of personality dynamics, which if recognized earlier would have given a clue to the child's management, this may be taken as a criticism and lead to strained relationships between the pediatric and psychiatric services. For example:

A 10-year-old boy had been admitted to the hospital following a blow to his knee. Several prior hospitalizations for similar injuries made the diagnosis of accident proneness obvious. Each accident had occurred in a reckless attempt to prove his courage. This time acute rheumatic fever in several joints had set in. This condition made it imperative for him to stay in bed and take medication regularly, both of which he refused to do after the acute phase of his illness had passed. He made it quite clear that he was trying to be thrown out of the hospital.

The boy's history revealed that he was the third of five brothers and very close to his mother. During the winter preceding hospitalization his father had been out of work and had made little effort to seek re-employment, although his mother was pregnant. The mother had entered the hospital to deliver while he was there and had promised to take him home with her when she left with the baby. However, he had not been ready for discharge when she left. Although the pediatric staff was aware of this, they had not made use of it in dealing with the boy and had not helped him to understand the source of his turmoil (anxiety over his inner wish to be the baby) and the reason for his intolerance of passivity and of being nursed.

The psychiatric consultant could not get across to the pediatricians that if an interpretation had been given to the boy at his first rebellion, which came just after the mother had left the hospital, and if he had been confronted then with the immediate source of his conflict, he might not have suddenly developed such a tremendous anxiety over his passivity; and that gradually then the boy might have been helped to face his feminine identification and his fear of losing his hold on his mother. The pediatricians were angered at the explanation of the problem, perceiving it as a criticism of themselves for not calling the consultant in earlier.

Experience has shown that for the psychiatric consultant to hold daily supportive conferences with the ward staff around a problem of management, and to exert pressure for one person to be put in authority to avoid conflicting orders, are far more useful to the ward pediatricians than confrontation with a piece of psychological insight, no matter how valid.

Observation Sessions

Also useful in helping young pediatricians to gain greater insight into the dynamics of child behavior is to encourage them to attend social group work sessions, where the children play out their fantasies and feelings, their primitive sado-masochism, their cannibalistic impulses, and their curiosity about the body and its functions, all of which the group worker accepts without criticism, holds within bounds, and gently moderates. Observations of such a session can be a most illuminating experience. Because of its educational value the social group work program at the Boston City Hospital has been incorporated in the Psychiatric Social Work Training Project, operated by the Boston University School of Social Work with a Federal grant from the National Institute of Mental Health.

Pediatricians usually welcome a "recreational" program for their patients and will accept proposals for changes in ward practices much more easily from the group work staff than from the psychiatric team. This is understandable since where there is a group work program it becomes an integral part of the pediatric service and is in operation on the wards all day every day. Nothing is more convincing to pediatric trainees of the emotional crises in the children under their care than to hear and watch the children perform amputations, beheadings, and other gory mutilations on dolls and gradually, with the encouragement of a skilled group leader, express their own anxieties about what has and will be done to them.

The psychiatric consultant will also find it helpful to encourage the psychologist to demonstrate to the pediatric staff testing sessions of children at various ages, in order to point out the many things about a child taken into account in making a judgment of his possible potentials.

New Approaches

A child guidance staff in a city hospital deals with a population group with which most psychiatrists have had little contact. Many of the children come from disorganized families which do not maintain consistent contact with any social agency. And, even if they did, one hour of therapy per week could hardly reverse the effects of the early deprivation and inconsistency suffered by their children. Therefore new approaches to treatment become necessary: the use of the special skills of mental health graduate nurses, therapeutically oriented nursery school teachers, and group workers, in addition to the usual child guidance team of psychiatrist, psychologist, and psychiatric social worker.

The following is an example of a combination of several approaches made by the child guidance clinic of the Boston City Hospital:

A 15-month-old girl, Doreen, on the pediatric ward with the diagnosis of failure to thrive, was brought to the attention of the psychiatrist. Underweight and undersized, she looked like a 6-month-old baby. She was unresponsive and showed no interest in toys, looking only at her hand which she would move in front of her face. Her 23½-year-old mother had three other children, aged 5 and 6, and another baby aged 1 month. Told early in Doreen's life that the child had a congenital heart condition, the mother was so frightened that she never put her on the floor to crawl, let alone to attempt to walk. Doreen had been kept in her crib all day every day where she had remained, undemanding.

The psychiatric consultant recommended that one attendant or nurse be given major responsibility for the baby, carry her about, play with her, and be generally affectionate and stimulating. In spite of staff resistance because of the administrative difficulties involved, the advice was followed. This was so successful that the baby gained considerable weight, and by the time of her discharge had learned to walk, much to her mother's surprise.

A child psychiatry fellow and a nurse working for her master's degree in psychiatric nursing were assigned to visit the home regularly once a week.

The psychiatrist's goal was to establish a relationship with Doreen, to stimulate her curiosity and her initiative, and to encourage her to master certain simple skills. At first the child rocked endlessly on a chair, humming in a sing-song fashion and often just staring dreamily into space. Gradually she responded to her visiting therapist and engaged in simple back-and-forth activities with him.

The nurse meanwhile related warmly to the mother and in a most supportive manner instructed her about the needs of babies. The mother learned not only to show affection to the new baby but also to Doreen. When the nurse's placement in the hospital's clinic ended, her place on the case was taken by the head social worker who, although she continued discussing methods of child care with the mother, gradually drew her into a casework relationship.

The case was progressing well when the mother became pregnant again. Another baby was born before Doreen was three. Arrangements for a homemaker at the time of delivery were canceled because the mother made plans for the paternal grandmother who was seriously emotionally disturbed to take over the care of the children.

When the new baby was brought home from the hospital, it seemed an excellent opportunity to combine child development observations (an aspect of the hospital's training in child psychiatry) with service. This brought a third person into the home, another psychiatrist in training who visited every fortnight. But by the time the new baby was 2 weeks old everyone was in a state of alarm. The mother seemed apathetic and depressed; she was rarely seen holding the baby and when she did so, showed inept, stiff handling. The baby was crying most of the night and Doreen was again withdrawn and rocking.

The social worker then learned that the father who had always inadequately supported the family had lost his job just before the mother went to the hospital; that this was the reason she had canceled arrangements for the homemaker. He was going out night after night and upon return home playing his hi-fi until 2 a.m. The social worker also learned that the paternal grandmother had frightened the mother about the shape of the baby's head, convincing her that she had another abnormal child.

A pediatrician was brought in to see the baby. He was able to assure the mother that there was nothing wrong with the baby's head, and he prescribed a formula that would carry the baby through the night. When the baby was 4 weeks old, the psychologist on the child development program came to the home to give the baby a developmental test and reassured the mother about the baby's mental normality. In 5 to 6 weeks the mother gradually recovered; it seemed to us a result of the great interest shown her and her children by so many concerned people who were able to be reassuring where she most needed it.

Now, 4 months later, the mother is becoming demonstrative with the new baby, a boy. Doreen has begun to be naughty and occasionally wanders away. At 3 years and 2 months of age she has finally begun to say a few intelligible words.

Much research needs to be done before we know whether we can salvage children who have been seriously neglected during their first 15 months—whether we can help them develop the trust they should have developed in their first 6 months or perhaps even during their first 3 months. It is not at all certain that Doreen will be able to progress beyond a dependent relationship to others. Her cognitive functions may also continue to be retarded. Ironically, the original diagnosis of congenital cardiac anomaly is now being questioned. In order not to disturb further Doreen's emotional development, the psychiatric consultant has persuaded the pediatricians to postpone exploratory procedures in this connection for the time being.

As regards Doreen's little brother, however, it seems evident that the fortuitous presence in the house of members of the hospital's child guidance team prevented another maternal rejection and perhaps another case of failure to thrive.

The etiology of failure to thrive has not been definitely established. There are so many babies that are neglected who *do* grow and gain that one is obliged to look either for specific elements of mothering care that those who fail to thrive have been deprived of or for qualities lacking in the baby. The effects of the timing of certain experiences must be subjected to much more intensive study. Genetic factors certainly should not be neglected in this search.

Areas of Potential Service

Psychiatric services to children over 12 in most city hospitals are still very inadequate. At the Boston City Hospital, adolescents are cared for in the adult wards, and the child guidance staff sees them only if they are referred by the adult psychiatric service. Closer collaboration with this service and a beginning effort to establish communication with the medical and surgical staff are under way, a process which must be continuous in a teaching hospital with a constant turnover in residents. At present most of the adolescents referred to the child guidance service are young people who have made suicidal attempts. They are usually most reluctant to reveal themselves and are terrified of "head shrinkers." Others might be encouraged to come for treatment.

The adolescents in a city hospital like the younger children and the parents of the babies offer the psychiatric consultant an opportunity to reach a population group otherwise little accessible to preventive intervention. Other areas where such an opportunity might also be grasped are in the emergency wards and the prenatal clinics of city hospitals.

If psychiatrists are to widen their preventive and therapeutic efforts to include a broader range of socioeconomic groups, vigorous psychiatric services that do not shrink from exploring new approaches are needed. However, they must be carried on with the same psychological sensitivity and exploratory urge that have helped to build an understanding of the psychopathology found in persons in the middle class culture.

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[1] Mason, Edward A.: Children in the hospital. (16 mm. film, black and white, with sound.) International Film Bureau, Chicago. 1962.

A study classifying parental factors behind abuse gives clues for . . .

PROTECTIVE CASEWORK FOR ABUSED CHILDREN

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IN AN EFFORT to classify types of cases involving physical abuse of children and how they are handled by a protective agency, a study was made in 1962 of 80 cases in which children had been severely abused by their parents or parent substitutes. The study was based on a sample of cases handled within the past 3 years by the Pennsylvania Society To Protect Children from Cruelty.

The study's definition of an abused child was: any child against whom bodily harm was done to such a degree that it came to the attention of the agency and resulted in the rendering of service to protect the child. Malnutrition, starvation, or sexual misuse in children were not included unless bodily damage was also done. Three major factors were considered: (1) degree of injury inflicted; (2) probability of the abuse recurring; and (3) physical and psychological availability of parents to casework help. The cases were categorized as involving abuse which results from: (1) parents' acute mental illness; (2) an overflow from the parents' aimless way of life; (3) a nonspecific disturbance in the parent resulting in severe battering of the child; (4) parents' harshness in disciplining children; (5) parents' misplaced conflicts.

Abuse by Mentally Ill Parents

In families where a mentally ill parent is physically abusing a child, the mental illness soon becomes so apparent and unpredictable that separation of abusive parent and child is imperative. If a spouse or other relative is available, the degree to which he can be of assistance in getting the abusive parent to a psychiatric resource needs to be quickly determined. If the case situation is essentially made up of mentally ill parent, abused child, and protective caseworker, the willingness of the parent to get needed treatment voluntarily or relinquish her child must be explored directly with her, for occasionally such parents recognize their own illness and give up the child. Should either approach fail and the child is obviously in immediate danger, the police are called on to transport the parent to a psychiatric facility. If the child does not seem to be in immediate danger, a petition in behalf of the child is filed with the appropriate court.

A withdrawn, 3-year-old child with an old and unsmiling face came to the attention of the protective service on a referral from a city hospital, where he had been treated for burned hands. Small scars were found on his entire body, some healed, some with scabs. His mother, a 22-year-old single woman, maintained that a caretaker had inflicted the damage to her son. An interview revealed that she felt "done in" by her parents who had given her as a baby to an aunt, by the aunt who had put her out when she became pregnant, by the father of the child who had deserted her, and now by her son who "wants things his own way." The caseworker, she said, could "take him away," but later she refused to give up her son for placement and it was necessary to file a petition with the juvenile court.

The mother failed to show up for a scheduled court hearing and had to be brought in later. A psychiatric examination resulted in the diagnosis "schizophrenic, paranoid type."

Of the 80 cases studied, 4 fell into the category of abuse by mentally ill parents. The focus of service was on how to most helpfully separate parent and child. In two of the four families, unwed mothers were the abusers. Both had histories of mental illness. The other two families had histories of severe marital conflict and mental illness in the fathers, the abusers. In all four families, the homes were above average in organization and cleanliness. In two of the four families, more than one child was abused. The method of inflicting abuse varied, but it always involved a ritual rather than an impulsive approach. The most common prelude was to devise a situation in which the child either became petrified with fear or was provoked into behavior which was unacceptable to the parent and thereby "justified" punishment.

Overflow Abuse

Overflow abuse includes parents whose claim to parenthood seems to be little more than biologic. Their lives are marked by illegitimacy, paramour relationships, misuse of income, repeated evictions, excessive use of alcohol, deplorable housing and housekeeping. They obviously cannot help themselves. The abuse of their children seems to be rooted in an overflow of their own frustration, irresponsibility, and lack of belief in themselves or anything else.

In such cases, the possibility of the family remaining intact is remote. The parents are generally vacuous, pleasure-seeking, and devoid of guilt, except for periods of extreme remorse and self-pity. They make promises easily and plead with the caseworker for "one more chance." Most such parents respond poorly to formal psychotherapy. They sometimes begin, but seldom sustain contact with alcoholic clinics. They rarely make meaningful use of casework help, except in short-lived spurts.

Life for the children of such parents is degrading and dangerous, especially for infants, who cannot run from indiscriminate parental behavior. Parental abuse is most commonly dealt to the older children, perhaps because older children are more likely to become aware of values different from their parents'. When the child rebels, the parents, lacking any responsible coping capacity, try to control his behavior with their hands. The casework focus in cases of this type is to test the parents fully, in the hope of finding a spark of strength. In some instances this testing arouses a parent enough to participate in placing the children with relatives or in foster care.

The agency received a report of three teenagers who were beaten by their parents and made to beg for money on threat of burning if they refused; the father was said to have made sexual advances toward the 13-year-old girl and beat her on the face and body with his fists. The report was verified. There seemed no possibility of making functioning parents out of the alcoholic father and mother, whose 17-year-old marriage had been marked by repeated separations. Since they were unable to recognize the adverse effects of their behavior, the children were committed to the care of interested relatives.

Of the 80 cases studied, 13 were categorized as overflow abuse. In more than half the families of this type the father was not in the home. In nine cases the abuser was the mother. In every case where there was a man in the home there was a history of severe marital conflict. In only two of the cases were the housing and furnishings adequate. In all but one case the income was from public funds, paramours, or relatives. All parents who were examined psychiatrically received diagnoses of "inadequate personality." Most of the abused children were over the age of 5. The beatings followed no pattern and were rarely directed to any one child. They were administered by fist or with a belt or strap, and were repetitive and prolonged. Five cases were handled on an emergency basis, four of which required immediate admission of the children to a shelter.

The Battered Child

The "battered child" syndrome takes its name from the fact that the child's injuries are the result of twisting, throwing, knocking around, or some other form of "battering" by the abusive person. The injuries include bruises, hematoma, and one or a combination of fractures of the arms, legs, skull, or ribs. In many instances poor skin hygiene and some degree of malnutrition are also evident. X-rays of the child often reveal other fractures in various stages of healing, indicating that such abuse has been repetitive. Abuse of this nature is most severe (sometimes fatal) and is most often inflicted on children who are too young to speak, thereby ruling out their explaining how the injuries occurred. While it is strongly suspected that the parents either inflicted the injury, or know how it happened, they are most reluctant to volunteer any information.

Accurate figures regarding incidence of this type of abuse are difficult to come by. Physicians' suspicions may not be aroused because parents may shop for medical care after each injury of their child from different hospitals and doctors, fail to get treatment at all, or fabricate stories to account for the injury, blaming an ex-caretaker, a relative, or a jealous sibling.

Fortunately, the recent investigations of Kempe and associates have gone far to alert the medical and other professions to the phenomenon of the battered child.[1] As a result, an increasing number of "battered" children are likely to come to the attention of child welfare agencies.

The process of dealing with physical abuse by battering usually begins at a hospital. Due to the severity of injuries, the child is brought there for treatment even if seen initially by a private physician. In some hospitals, if parentally inflicted trauma is suspected, or if the child is suffering from malnutrition with no apparent medical cause, the child's entire skeletal system is scanned by X-ray. Discovery of internal injury strengthens the physician's suspicions that more than medical treatment is needed.

Whether or not the police are alerted to the situation, the attending physicians should be required to refer the case to the hospital's social service department. The medical facts, along with a social service study of the emotional factors behind the child's injury, should indicate whether the child is in need of protective service. If so, such information as regularity of parents' visits with the child, their attitude, demeanor, use of social service, if any, and pertinent medical facts should be included in a referral to the protective agency. The parents should, of course, be informed of the referral so that a contact from the protective caseworker will not be the first indication they have that something is amiss. This will not, however diminish the force of the initial impact of confrontation between the protective caseworker and the parents.

If the injured child has not been discharged from the hospital, the protective caseworker assesses the home situation, parental attitudes, the validity of the parents' explanation of how the injuries were incurred, and the strength of the conviction with which they express desire for the child's return. Should it be obvious from parental attitude or behavior that the child should not be returned home, alternate plans for his discharge from the hospital will be attempted, either with or without court action. If the caseworker sees no immediate danger for the child in the home, he may support the child's return on condition that the parents continue to use the agency's service. This involves risk, but it also involves an opportunity to assess the situation by observing the child in his customary environment including all the familial cross currents and especially the manner in which the parents and child interact.

A small infant's fear and withdrawal from an intimidating and abusive parent are hard to detect except by spending hours with the parent and child. Conversely, an abusive parent often acts out his or her conflict with the battered child in the presence of the protective caseworker. Although this is done in miniature and with a parental air of acceptance of the child, the rejection seeps through in manifestations of intolerance and aversion to the abused child, indicating that the injury was more than an accident or an isolated impulsive act. In such instances, a separation from the family needs to be seriously considered, either of the child or the abusive parent. I know of no case of classical child battering in which the child has been able to remain safely with the abusive parent. Even when the parent accepts psychiatric help, separation is called for during the course of treatment, and precipitate reunions must be guarded against.

A family consisting of a young commercial artist, his wife, and two children, aged 2½ years and 1 month, was referred to the protective agency by a city hospital when the older child was admitted with fractures of the left femur and multiple bruises. The parents gave vague and conflicting stories to account for the child's injuries. In a series of separate and joint interviews with the parents, the protective caseworker found that the father had a pattern of abusing the child. The child had been a year old when the parents were married and the parents had already been separated and reunited twice during the brief period of their marriage. In the interview, the mother vacillated between minimizing her husband's behavior and expressing doubt and fear of him. The father who was obviously immature and indecisive, though with strong feelings, acknowledged having some part in the injury, which happened while he was bathing the child.

The protective worker concluded that it would not be safe for the child to return to his father upon discharge from the hospital. The mother concurred, separated from her husband, and moved into the maternal grandmother's home with the children.

For the next 3 months the caseworker continued having interviews with both parents, mostly with the mother, for the father rarely kept appointments. The father agreed to accept referral for psychiatric treatment but never followed through. Meanwhile he kept asking his wife to return to him. She finally yielded to his pressure and informed the caseworker of her intention. Since the protective agency had no authority to keep the parents from reuniting but felt strongly that such a move would place the children in grave jeopardy, it filed a petition in juvenile court in their behalf. However, the court condoned the reunion of the entire family on condition that both parents receive psychiatric treatment. A few months later the abused child died as a result of a blow on the head from his father.

Of the 80 cases studied, 8 were classified as battered child abuse. In six families containing more than one child, only one of the children was abused. In one family containing two children, both were equally abused; and in another containing three children, all were abused.

In four of the eight cases, a parent admitted that he "might have" caused the injury, but professed no intent to hurt. In all cases there was long standing, severe interpersonal conflict, either between parents or between the abusive parent and a significant relative. Psychiatric evaluation failed to reveal discernible psychosis in any of the parents. The most salient personality trait of the abusive parent in adult relationships was dependency. The injured child was invariably seen by the abuser to be either a competitor or a burden which had to be destroyed or at least made to suffer.

As in the case presented here, the nonabusive parent often separates from the spouse in order to protect a battered child but a few months later becomes reconciled. It is this all-forgiving, naive attitude, plus the fact that the continuing physical and emotional danger to the child cannot be seen and verified, which plague the protective caseworker and the court attempting to deal with cases of battered children.

Disciplinary Abuse

The category of disciplinary abuse includes children who are physically abused either for failing to comply with a parental expectation, or for having committed some forbidden act. All but one were at least 7 years of age, the majority being adolescents. The abuser was usually rigid and unfeeling.

Because of the age of the child, the caseworker tries to draw him into an ongoing relationship, to help him determine whether he is contributing to his own abuse and if so to decide what he can do about it. Often the child will acknowledge that he has been less than fair-minded and pliable on many issues. The parent usually acknowledges the abuse but always minimizes it. The caseworker must walk a tight rope, for this type of parent is standing firmly on parental rights. The casework focus is basically one of accepting the parental intention, but consistently trying to help the parent to moderate his methods.

Use of casework service by such parents may be called excellent in near-term protection, but only occasionally satisfactory for long-range prevention. The paradox of these cases is that the parents are usually upstanding citizens in the community. The abuse comes to light only when some family member (usually the abused one) releases his pent up feelings beyond the family confines. Protective intervention is intolerable for the parents in most of these cases, and they graciously comply with the agency's expectations in order to get the caseworker out of their lives.

This continually forces the agency to take a policy stand—that a parent cannot choose to discontinue use of service simply because he or she has stopped beating the child and promises not to do it again. Therefore, ***if the parental conflicts which have resulted in child abuse have not been substantially resolved when the parent wishes to discontinue service, legal action is usually initiated in behalf of the child.*** Such action generally results in a court decision that the abusive parent seek psychiatric help, family counseling, or be supervised by the court, or a combination of these alternatives. Danger to the children is rarely sufficiently clear for the court to decree their removal from home. And the children seldom choose to leave. In these cases, agency service acts as a safety valve.

> The police brought three children, boys age 14 and 12, and a girl age 10, to the protective service shelter. They had come home a little late and had been severely beaten with an extension cord by their father, a truck driver and lay minister. The mother had interceded by enlisting police help. A warm, outgoing woman she told the caseworker that the beatings occurred often and had grown more severe. She was agreeable to the children's admission to a shelter.
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> These parents of six children acknowledged marital conflict of long duration. The mother obviously loved her children deeply and regarded them as responsible and well-behaved. The father, a cold stiff man, exaggerated their misbehavior. He acknowledged the beating saying maybe this time he went a little too far. He said it was his right and responsibility, and he did it so the children would not get into trouble.
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> Within 2 weeks, the mother and father both maintained that things were straightened out at home and insisted that the children be returned. As much help as possible was given prior to the formal court hearing. The father said he had moderated his views somewhat, but a good bit of this was obviously just going along with what he felt was expected of him. A neuropsychiatric examination resulted in diagnosis of "schizophrenic reaction, paranoid type." The court ordered that the children remain with their parents under court supervision and that the father be referred for intensive psychotherapy.

Twelve of the 80 cases studied were classified in the category of disciplinary abuse. Included were all (5) in which the abusive person was a parent substitute, usually a person at least 50 years old who was caring for the children due to parental default rather than by choice. All homes but one were spotless. The abuse usually took the form of severe beatings on all parts of the child's body, usually with some implement—strap, rope, stick—rather than the bare hands or fists. Abuse was not centered on one particular child, but on any child who "broke" the rules of expected behavior. Marital conflict was more underground than blatant.

Misplaced Abuse

The category of misplaced abuse contains cases in which a parent's conflict is being projected onto the abused child. Routine case study invariably reveals an essential family unit with parents in varying degrees of marital conflict *and* some situations which prove to be at the core of the abusive behavior. These include:

1. Conception prior to marriage. Either parent may punish the child for forcing an unwanted marriage.
2. An illegitimate child (usually the woman's, sometimes adopted by the stepfather). The stepfather may beat the child as a bad part of the mother; or the mother may beat the child as a part of the bad man who "did this and ran," or as the "thing" which caused her to lose him.
3. A brain-damaged child viewed as willful by a parent, who tries to beat out the "badness."
4. A child who has had his mothering process interrupted by the birth of a sibling. His natural reaction against this imposition may be handled so inappropriately that he further reacts, receives punishment, reacts more, and gets more severe punishment.
5. A child who has become a pawn in the conflict between parents, or between a parent and relatives, a "defeatable" substitute for a formidable adversary.
6. A badly handled separation of a child from the family and his precipitate return.

While some cases of "battered children" also fit into this category, the similarity holds more in the assessment than in their management. In the battered child category, severe and even fatal injury to the child is not uncommon and must constantly be guarded against; the abusive parent seems unable to control his behavior or feel much guilt about it; and resolution of his disturbance is apparently not within the present competence of casework skill. The converse is true in cases of children being abused due to misplaced parental hostility. Such children, although in a damaging situation, are rarely in danger of death; the abusive parents frequently manifest deep guilt and are able to control their behavior. Of all the groupings, parents in this category have demonstrated the greatest capacity to engage in a casework relationship in an effort to resolve the problems underlying their abusive behavior.

This does not mean that protection is an easy matter in these cases. In addition to the usual client resistance, the caseworker must deal with unacceptable child care which cannot be blamed on the neighborhood, insufficient income, or inadequate community resources. The parent is directly involved through deliberate action rather than failure to act. The caseworker can count on no assistance from either parent, for the parents initially protect each other regardless of the intensity of their disdain for each other.

Of the many approaches to breaking through the parents' armor, two stand out: (1) When the parents deny the abuse and maintain that the child is lying, the caseworker engages them in a discussion of the significance of the child's need to lie to someone regarding such a serious matter as a beating by his parents. (2) When his suspicions are confirmed by observation of fear or acting-out behavior on the part of the child, he patiently calls this to the attention of the parents and appeals to them to join with him in an effort to help the child.

The caseworker lets persistence and discretion be his guiding principles. Almost without fail, the agency intervention acts as a brake on the behavior of abusive parents; so the caseworker may be content with a momentary impasse as a calculated risk toward demonstrating some trust in the parents to insure that he will be able to see them again. At this juncture he weighs the advisability of interviewing the abused child. If there seems to be danger, he will pull out all stops in behalf of the child. Otherwise, forcing an interview with the child may only aggravate matters. ***The most important aspect of protecting the child is not to prove the parental abuse, but to make a reliable assessment of the apparent danger for the child and somehow elicit a commitment from the parents to further discussions.***

In subsequent interviews, the full extent of the problems in the home is invariably aired, thus making possible a thorough evaluation of the situation. Usually at this point either continued protective service is agreed upon, or the parents flatly refuse the agency service. In the kinds of cases included in this study, the abuse is so severe that parents' refusal of service necessitates initiation of court action.

Some children who have endured misplaced abuse are so emotionally disturbed by the time they come to the attention of the protective agency that psychiatric treatment is clearly indicated. Many abusive parents are also in need of psychiatric treatment, but most of them receive the suggestion as either a joke or an insult. However, some regard it as a magical means of achieving quick alleviation of their problems. Either view when not adequately handled before referral for psychiatric service leads to rejection by the psychiatrist because of "insufficient client motivation, home too unstable to warrant treatment, client inability to acknowledge problem."

Ever present in dealing with cases of misplaced abuse is the caseworker's awareness that the children are in danger of further damage as long as they remain incorporated in the parents' acting out of a marital conflict. In protective service such conflict is handled through employment of generic concepts of casework help, plus the extra leverage of authority, and a steady focus on relating parental attitude and behavior to its effects on the children. If this help brings about a healthier balance in the family, to the obvious benefit of the abused child, either termination of service or referral to a family service agency is considered.

Where the union between parents has never been anything more than legal, or not even that, separation of parents, or parents and child, may be necessary to protect the child. If parental separation is advisable, the father usually leaves the home, sometimes under court order. The need to separate a child from his family might be immediately apparent to the caseworker, or recognized only after months of service. In either case, the goal is the same—to determine whether long-term placement seems essential, or whether through skillful help, eventual reunion on a more satisfying level can be achieved.

A family of 2 parents and 11 children was referred by a neighbor, who said that the children were beaten. Investigation was difficult, with threats to the caseworker from both parents. Yet within a month the parents were keeping regular appointments with the caseworker, some in the office. What came to light was that there was violent conflict between the mother and the oldest boy, Joey, who had been conceived before the parents' marriage and had spent his first 7 years with his maternal grandmother. Since Joey was big and not inclined to yield to his controlling, moody mother's unreasonable demands, the task of discipline was forced on the father. The father said that he began beating Joey "normally," but when the boy laughed at him, became incensed and started beating him with his fists. He later expressed uncertainty regarding his having fathered Joey.

When it became obvious that the child could not stand any more beatings, yet the mother was continually provoking them, the three family members agreed with the worker that a separation was needed. While in temporary shelter, Joey was seen regularly by the same caseworker who was holding regular interviews with his parents. Weekly visits between parents and Joey were scheduled, which the parents always kept. Gradually all three family members learned to trust and express themselves with the caseworker, and then to give respect to each other.

Eventually parents and child were spontaneously embracing each other and expressing the hurt and loss that they had been feeling before and during the separation. Within 5 months all three were showing sustained improvement and gratification in their relationship, and Joey pridefully returned home.

Of the 80 cases studied, 43 illustrated misplaced parental abuse. In homes where the father was present, he was most frequently the abuser. As in all categories, except overflow abuse, the homes were clean, orderly, and adequate. Only 4 of the 42 families were receiving public assistance. In 32, there was severe marital conflict, with much indication of mismatch between parents—mother quietly self-pitying, father explosive; mother pliable, father rigid; mother self-righteous, father fair-minded. The parents' family backgrounds included stress and disruption but not to an excessive degree.

In 29 cases the child was either illegitimate, conceived prior to marriage, cared for off and on by friends or relatives, or had been considered for foster placement at least once. In 33 cases, all multiple-child families, only 1 child in each family was being abused. The abuse usually was in the form of beatings with fists or a strap and was severe enough to cause bleeding, welts, bruises, police intervention, or need for medical care. In 34 of the homes, the beaten child was at least 5 years of age. Most of the abused children were manifesting internal turmoil by bed wetting, truanting, firesetting, or withdrawal.

Need for Joint Effort

While this study sheds some light on child abuse, it clearly indicates that much more needs to be known about the distorted views of abusive parents and the mechanisms which trigger their damaging behavior. To undertake a study of the entire problem of abused children is obviously bigger than any one profession. Satisfactory results may be obtained only through joint professional endeavor. Yet, knowing that physically abusive parents are resistive to seeking help voluntarily, additional knowledge about them will unquestionably have to come largely from some authoritative reaching-out source, such as a protective service.

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[1] Kempe, C. Henry; Silverman, Frederic N.; Steele, Brandt F.; Droegmueller, William; Silver, Henry K.: The battered-child syndrome. *Journal of the American Medical Association,* July 7, 1962.

JOB-RELATED EXPENSES OF THE WORKING MOTHER

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ANY HISTORICAL review of the contribution of wives and mothers to the economic well-being of the family will show clearly that the income-producing wife is not exclusively a phenomenon of modern society, but rather a significant part of our American heritage. Before the turn of the century, women contributed appreciably to higher family living standards through the production of clothing and food for marketing or for home consumption. Taking in boarders was another way of making money at home. In the early 1900's, 23 percent of the wage and clerical workers' families included in a cost of living survey made by the then U.S. Department of Commerce and Labor had income from boarders and lodgers.[1] Before the days of the Social Security Act with its provision for Old-Age and Survivors Insurance, many a widow supported and educated her children from such earnings.

Our present form of industrial society offers the housewife little opportunity to earn money at home, and today one wife out of every three has joined her husband as a wage earner in the labor force.[2] The employment of wives and mothers is not new; what has changed is that they are employed in increasing numbers outside the home. Such employment necessitates job-related expenditures, frequently of sizable proportions.

Today many a woman faces the question: *Should* a mother take a job outside the home? As in all decisions which relate intimately to the well-being of the family, this must be answered individually by each family. Is the plan agreeable to the husband as well as to the wife? Is the woman clear about her motivations for working and are these sound? Is she able to make good provision for the care of children? Has she calculated the extra costs entailed by her working and what the net gain to family income will be? The choice will be "yes" for one family, "no" for another, or "yes and no" for the same family, depending on its stage in the life cycle—"no" when the children are young, and "yes" when they are grown.

Among the multiplicity of motivational factors, the need for money is often given as the reason or one of the reasons for which mothers with income-producing husbands seek wage-earning jobs outside the home. In making long-range money management plans, parents usually give top priority to goals for their children's education, for better social and cultural opportunities for them than they themselves had, for maintaining or upgrading family living standards. The wife's employment can often supply the discretionary income toward such goals. Over and beyond this, however, is the fact that having earnings of her own frequently provides a wife with a measure of economic independence and more freedom to give consideration to her own needs and wishes for better clothing and for participation in social, cultural, and civic activities for which she may hesitate to spend money when all family needs must be met solely from her husband's earnings. In considering the factors which prompt a wife to seek employment, the desire for some degree of economic independence is probably not one of great importance in relation to others, but it is undoubtedly of significance to many wives.

Data from existing studies[3] and the experience of family counselors clearly indicate the complexity and variation in the reasons why mothers work, though the need or desire to increase family income is often the major reason, or closely related to the major reason, for which homemakers accept wage-earning jobs outside the home. However, dependence on such a job to solve economic problems is a questionable solution when anticipated net gain is not clearly identified and the expenses of working not taken into account, or when a family is not ready to modify the spending habits which provoked the economic problem in the first place. Take the Murrays, for example:

> The Murrays applied to a family service agency for counseling at a time when their anxieties about unpaid bills and the attendant financial pressures threatened an already precarious marital relationship. Mr. Murray had steady and secure employment as a civil service employee. His income would have been adequate to support his wife and two children at a modest level only if it had been managed with great skill and there were no extraordinary needs. But Mrs. Murray, who had married when she was still in high school, had made little progress in home management. Moreover, the family had had high medical expenses and, like many of their contemporaries, the young couple had sought through the use of credit to maintain a standard of living beyond the husband's ability to support. In an effort to help meet their mounting debt, Mrs. Murray had found employment, but at the time of application to the family service agency she and her husband were completely discouraged. Mr. Murray said, "Though we're both working and have a fairly good income, we still have nothing to show for it but debts."
>
> It was apparent to the caseworker and home economics consultant who analyzed the family income that though the Murrays had made some progress in debt payment, their method of doing so only increased family tensions. Often their payments could be made only if their rent was not paid, or their rent could be paid only at the cost of another lapsed debt payment. Despite an income of $132 weekly, the expenses the family sought to meet exceeded their income by $30. Problem areas were identified in high maintenance costs for food, medical care, insurance, and car upkeep, and in the $50 weekly debt repayment plan to which the family had committed itself.
>
> The Murrays were able with the help of the social caseworker to reconsider needs and goals and to make necessary adaptations. This involved taking into account Mrs. Murray's job-related expenses in preparing a family budget, working out a repayment plan with their creditors to have debt payments reduced to an amount which was within their income to meet, looking at the realities of their money management, and making necessary adjustments.

The Teller family was another in which the wife went to work to cope with a problem of serious indebtedness:

> Mr. Teller not only had a fairly well-paying job but supplemented this with a second job several evenings and weekends. Mrs. Teller also had a full-time job and in addition earned some income by doing clothing alterations at home. Job-related expenses were compounded by high transportation costs and restaurant meals for Mr. Teller, private nursery care for the youngest child, and high maintenance costs for running the home since Mrs. Teller had little time or energy left for home management.

The Tellers represent an extreme example of a family's choice in setting a goal for a standard of living requiring nearly all the energies of the husband and wife to meet. Nevertheless, it illustrates how some families rely on increased income to achieve unrealistic goals and to make up for poor home management practices. When families like the Tellers are not able to restrict their spending and to mobilize their capacities for better management, the purposes for which they work so hard and for such long hours have little chance of being realized.

Work-Related Expenses

There are two approaches to estimating the work-related expenses of an employed wife: (1) the use of data available from an increasing number of studies made of employment costs; and (2) the use of costs figured by home economists on the basis of scientific family budget data and consumer studies. That there is great variation in needs and money management from family to family in all areas of spending is generally recognized. This is equally true of work-connected costs. In the use of either method of estimating the expenses attached to a mother's employment, two important cost variables will be: (1) whether employment is full or part time, and (2) the cost of child care, particularly if the family includes children of preschool age.

Expenditure data from surveys of the U.S. Department of Agriculture[4] indicate that average work-related expenses take one-third of the wife's earnings and when there are school-age children the amount increases to one-half. In a recent study made by the Texas Technological College working wives had annual average earnings of $3,308 and, when they had children under 17, used 51 percent of their earnings for expenditures made necessary because of their employment.[5] Since this percentage is an average, the net gain in income would have been appreciable for some families and infinitesimal for others. Other studies have produced similar results, and confirm the need to give attention not only to the family's total earnings, but to the *net* amount the family income will be increased when a wife works. One-third of all wives who work have part-time jobs.[6] Such employment undoubtedly relieves much of the pressures from the wife who carries the dual role of homemaker and wage earner. Certain expenses related to working can often be reduced or eliminated. For example, if a mother works only during the hours her children are at school, she will not have to hire a caretaker for her children, except

JOB-RELATED EXPENDITURES OF THE WORKING WIFE IN NEW YORK CITY

Expenditure	Per week	Per year
Lunch	$4.75	$247.00
Transportation to work	3.00	156.00
Union dues	.80	41.60
Additional cost of clothing	2.55	132.60
Additional cost of personal care	.40	20.80
Additional cost of laundry	1.15	59.80
Social security tax on a salary of $65 weekly	2.35	122.20
Total	$15.00	$780.00

To this basic budget a family with children must add child-care costs. Preschool and nursery care costs in New York City range from a few dollars to $25 weekly. In families for whom such costs are $15 weekly, another $780 yearly must be added, with a resultant total cost of $1,560.[9]

when the children are ill. Other work-connected costs can be kept to a minimum when the wife has time to be a discriminating shopper and to give more care to clothing, home upkeep, and other household tasks.

In estimating job-related costs, expenses for needs essential to employment as well as those in which there is some element of choice should be taken into account. Major expenditures of the employed wife include:

- **Federal and State taxes.** Not only is the wife's income taxed but the addition of her earnings places the joint family income in a higher tax bracket.

- **Social security taxes.** Each employed person is taxed 3⅝ percent of the first $4,800 of annual earnings.

- **Occupational expenses for specific jobs.** These may include dues to unions or professional organizations, uniforms, job-related publications, and attendance at meetings.

- **Meals outside the home.** In addition to the lunches and snacks purchased by the employed wife, lunches may have to be bought by school children in the family because the mother is not at home to prepare them. Some studies have indicated that when the wife works, families eat more meals away from home and pay more for them.[7]

- **Child care.** Many day-care centers charge fees according to ability to pay, using scales which usually range from a few dollars to about $15 weekly. For other child-care provisions, the range may be considerably greater, for example, from free child care provided by a grandparent or friend to the high cost of a full-time nurse or maid.

- **Transportation.** Transportation to a child-care facility as well as to and from the job may be needed.

- **High cost foods.** Among the urban families included in the 1955 Household Food Consumption Survey of the U.S. Department of Agriculture,[7] there was little difference in the adequacy of diets between families of employed and nonemployed wives. However, the food patterns of the two groups did differ, the per person expenditure for food being about 10 percent higher in households where the wife was employed. Major differences were in the use of greater amounts and more expensive kinds of meats, poultry, and fish, of bakery products, and of other "convenience" foods. These foods are more costly than others with equivalent nutritive value, but the timesaving aspects of their use is an important factor in their choice by the employed wife.

- **Clothing.** In the families studied by the U.S. Department of Agriculture,[8] employed wives spent twice as much for clothing as those who were not employed. The working wife does need more and different types of clothing than the housewife. However, undoubtedly many wives who increase family income by earning money themselves may also feel they are in a position to satisfy a womanly desire for more and better clothes. Because the working wife has less time for shopping, clothing alteration and mending, an increase can also be expected in the cost of clothing for all the family.

- **Personal grooming.** Working wives spend more than nonworking wives on personal grooming, such as beauty parlor services. As with clothing, this may be made necessary in part by the fact of employment, but it may also be related to a wider participation in social activities among those who are employed.

- **Paid household help.** As would be expected, wives who work spend less time on homemaking than housewives and use more paid service, at a higher cost, for household tasks. The largest increase in expenditures of working over nonworking wives in the U.S. Department of Agriculture studies was for housework and commercial laundry services. These were about twice as high in families where the wife was employed. In families with children under 6, the prices paid for these services by the working wives were also consistently higher.

- **Other expenses.** Working wives often have extra expenses connected with their employment, such as gifts for fellow employees, employee parties, or transportation on the job not reimbursed by the employer. These vary with the job environment.

Family budgets developed by home economists in social agencies usually recognize the necessary expenditures related to working. For example, the Budget Standard Service of the Community Council of Greater New York has estimated that in New York City the fact of a wife's employment must add at least $15 a week or $780 a year to the family budget, *not* counting the costs of child care.[9] (See table on page 221.)

This standard budget does not include many of the added costs for which studies indicate the employed wife spends more than the nonemployed. Excluded are many of the "hidden" or work-connected costs revealed in the expenditure studies, which are frequently appreciable in amount—increased food costs for meals at home and eaten out, higher clothing costs for all family members, more paid household help, and the working wife's less restricted spending for personal needs.

Community Needs

The high cost of working needs to be recognized not only by the families in which wives and mothers are contemplating going to work, but also by community leaders and the agencies which serve families and children. There is urgent need for attention to:

- The scarcity of low cost, high quality day-care services for children.

Since trends in employment indicate that working mothers represent a permanent and growing proportion of the labor force, assuring that good child-care service is within their reach protects both the child and the family budget. According to a 1-day survey made by the Bureau of the Census at the request of the Children's Bureau in 1958, some 400,000 children of working mothers were left on their own while their mothers were working.[10] The recent earmarking of Federal funds for day-care services under the authorization of the 1962 amendments of the Social Security Act has provided an impetus for more adequate provision of services for such children.

- Budgetary practices in public assistance programs which fail to insure the meeting of basic family needs, including realistic and adequate provisions for job-related expenses of the employed mothers.

Pressures on mothers to seek employment must be questioned if they ignore the choices of the mothers and the needs of her children, and if net economic gain from the mother's employment is insufficient to provide an incentive.

- Health and welfare agencies' failure to take into account job-related expenditures of a wife's employment in setting fees for service and scales for determining relatives' responsibility to support a dependent family or individual.

Many families who are expected to pay fees or to support relatives are in this income class only because the total family income includes the earnings of a working wife. Adjustment in fees or support expectations should be made to take the wife's employment costs into consideration.

- Public housing for which income limits for eligibility and continued occupancy are specifically defined.

Such income limitations are usually related to family budget costs for the one wage-earner family. When the wife's total earnings are included in the income determination—without taking into account the costs of her employment—the family may become ineligible for public housing even though unable to afford other adequate housing. In at least one large city, documentary evidence of job-related costs of a wife's working provided by a social agency's home economist has been influential in securing adaptations in housing regulations to allow for adjustment of income limitations applying to families with more than one wage earner.

- The scarcity of job opportunities with working conditions feasible for wives and mothers.

The availability of more part-time jobs, for instance, would make it possible for some mothers who feel it necessary to add to the family income to find the kind of work which would permit them to meet the requirements of the job as well as their own personal needs and those of their family, without excessive expenditure of physical and psychic energy. Since work-connected costs would also be less, the economic as well as the social gains to the family in which the wife only works part time might well be greater than in a family in which the wife is employed full time.

- The lack of sufficient skilled counseling services in some communities for families who have problems with which they need help.

Intrafamilial strains are always aggravated when the family's income is too low to meet an acceptable standard of living, but when a wife works outside her home to increase the family income, other problems often arise. We have seen in the Murray case how more strain within the family may result from the immature use of the extra income to obtain unrealistic goals. Family counseling can help families see where the strain comes from and how it is being aggravated and to take realistic steps to ease the tension. It can also deal with problems related to the wife's working that have little to do with expenditures. For example, a couple's marital balance may become upset if the wife's satisfactions at work or fatigue from the job detract from her interest in the home, or if her newly gained self-confidence becomes threatening to the husband—often the case when the wife's earnings exceed the husband's.

Many factors ought to be looked at closely in determining what a mother's working is costing or might cost her family—not all of which can be measured in dollars and cents. However, those that can be identified and estimated as budgetary items are often overlooked in the making of individual family decisions as well as in the making of social policy.

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[1] U.S. Department of Commerce and Labor, Bureau of Labor: Eighteenth annual report of the Commissioner of Labor, 1903: cost of living and retail prices of food. Document No. 23, 1904.

[2] U.S. Department of Labor, Women's Bureau: Handbook of women workers. Bulletin No. 285. 1962.

[3] Herzog, Elizabeth: Children of working mothers. U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 382. 1960.

[4] Holmes, Emma G.: Job-related expenses of working wives. U.S. Department of Agriculture, Agricultural Research Service. 1958.

[5] U.S. Department of Labor, Bureau of Labor Statistics: Net contribution of working wives in Texas to family income. *Monthly Labor Review*, December 1962.

[6] ———: Marital and family characteristics of workers, March 1960. *Monthly Labor Review*, April 1961.

[7] U.S. Department of Agriculture, Agricultural Research Service: Household food consumption survey, 1955. Report No. 15. 1955.

[8] U.S. Department of Agriculture, Consumer and Food Economics Research Division: Clothing expenditures of employed wives. *Family Economics Review*, September 1962.

[9] Community Council of Greater New York, Budget Standard Service: A family budget standard. New York. 1963.

[10] Lajewski, Henry C.: Child care arrangements of full-time working mothers. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. CB Publication No. 378. 1959.

SUBURBAN YOUTH

Whatever other expectations people have for suburbia, high on the list is the goodness of environs for family life. . . . Is it possible that in our middle-class desire to give our children "a better chance than we ever had" that we have deprived them of some of the hurdles which made us what we are? In a world which is increasingly requiring decisions which affect all peoples, can our youths so shielded from knowing other kinds of people be intelligent about the problems of the day and age of which they are a part? What kind of selves emerge when youths grow to maturity without a chance to validate conceptions of self against any others save those who are like themselves in race, economic circumstances, and general occupational backgrounds of parents? Is it possible that they are too cloistered for the citizenship demands of the world of which they are a part?

Dan W. Dodson, director, Center for Human Relations and Community Studies, New York University, to the 1962 forum of the National Conference on Social Welfare.

HALFWAY HOUSES FOR DELINQUENT YOUTH

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THE POSSIBILITIES offered by "halfway houses" in programs for delinquent youth are receiving an increasing amount of attention throughout the country. In spite of this interest, however, there has been more hesitancy to proceed in their development in this country than in many countries abroad. Noting this, Roul Tunley who has studied measures to combat adolescent delinquency in various parts of the world has pointed out that: "the youth hostel, the aftercare home, and the halfway house have all been developed abroad recently in an attempt to devise a homelike atmosphere in which a child can work, live, and study in partial but not complete freedom." [1] He reports that in some cases children are sent to such facilities instead of to a reformatory or training school. In others, the facilities "are used as a bridge to help a child back from an institution into the mainstream of life."

The halfway house has been described by many persons in various ways. But each definition agrees on the basic principle that this is a residential program, the purpose of which is to bridge the gap between a completely institutional life and a completely free life in the community. For example, participants in a recent conference on halfway houses for delinquents settled on the definition: "decentralized group living situation involving a limited number of adolescents." [2] The Bureau of Prisons, U.S. Department of Justice, refers to its halfway houses as "pre-release guidance centers." They are seen as "a means for the orderly reintroduction of the offender into the community through the use of all available community resources, together with a structured guidance and counseling program." [3]

The youth for whom programs of this nature appear most helpful are those who have no home to return to, those whose own parents are sufficiently inadequate or rejecting to give them the necessary guidance and support for a successful adjustment, those whose parents may be fostering their delinquent behavior, or those whose parents live in neighborhoods in which the youth are unable to cope with the many pressures they would face upon return.

Halfway houses as supportive services between institution and independent community life appeared first in this country not for delinquents, but for mental patients and for young people who were ready to leave child-caring institutions and who could not be placed with foster families or returned to their own homes. While small group homes for adolescents are apparently increasing, especially under the auspices of voluntary agencies,[4] the development of halfway homes for the mentally ill has apparently not been rapid. According to a survey conducted by the Joint Commission on Mental Illness and Health in 1961, only nine such residences existed at that time—and of these, seven had been developed in the preceding decade.[5]

The appearance in this country of halfway houses for delinquent youth is even more recent and scattered, the few that exist under State auspices having been opened hardly more than a year or two ago. One or two, under the auspices of large county agencies, were set up earlier. But there are increasing indications that the appropriateness of this type of facility in a treatment program for deliquents is beginning to be recognized. For example, in April 1961 the Maryland State Department of Public Welfare and the Health and Welfare Council of the Baltimore Area, Inc., held a conference on halfway houses which was attended by 31 persons from local and State child-care programs. At this meeting it was pointed out that many delinquents remain in institutions longer than necessary because there is no other place for them to go.[2]

Because of this interest it is pertinent to take a look at the experience of some of the few halfway houses for delinquents which have been established in the past few years in an effort to pull out some guiding principles on how such programs might best be used.

A Girls' Residence

The New York State Training School for Girls in August 1961 opened a group residence for girls who are ready to return to the community but unable to go home or to adjust in a foster home. A four-story apartment building, formerly operated as a girls' residence by the Community Service Society of New York City was purchased by the training school. It accommodates 16 girls. In addition to the full-time director, staff consists of a full-time social worker, a housefather, three housemothers, and two part-time activity leaders.

When the program was established it was decided that two groups of girls would be accepted, those who would be attending school and those who would be employed full time. Girls were to be over the age of 16 and on parole status from the institution. After a short period of time the staff decided to limit intake to girls who would be employed full time.

The decision not to accept any more school girls arose from difficulties encountered in combining the two groups of girls with such different program needs and from the lack of experience in operating such a program. One problem arose from the fact that the school girls needed time in the evenings to do their homework, and, because they were on the whole younger than the working girls, needed to be home earlier on school nights. The school girls found these limits difficult to accept when they saw that the girls who were working were freer to go out in the evenings and were allowed to stay out later. Moreover, the fact that the employed girls had spending money and dates tended to influence school girls to leave school. However, after the staff gained confidence and skill in running the program, the agency again accepted girls who would be attending school, with no more serious difficulties.

Further complexities arose in the program, however, as girls encountered difficulty in obtaining employment. The problem apparently stemmed not only from the limited availability of employment but also from the girls' lack of job training. Moreover, some of them also had emotional problems severe enough to prevent an adequate employment experience. Thus the staff faced many difficult problems in the attempt to provide rich experiences for the girls, particularly in relation to those who were not working, for the girls became increasingly disturbed when unable to obtain or hold employment. It was concluded that additional trained counseling staff is necessary to help the girls during these periods of stress.

The experience with 18-year-old Mary illustrates some of the problems faced by the staff in this program:

> Mary came into the residence after having been in the State Training School for Girls approximately 10 months. Her mother had died when she was a little girl and she had gone to live with her maternal grandmother, an extremely rigid person. Her father, who had remarried, was critical and rejecting of her, but he did continue to see her after she had been sent to the training school.
>
> When Mary first came to the halfway house she would resist any attempt on the part of the staff to work with her. Outbursts of temper seemed indicative of her inability to trust authority. After several contacts with the accepting, supportive social worker, Mary became less explosive and more accepting of authority. Gradually she began to tell the worker of her feelings of rejection. In spite of her improvement in the residence, when the father visited he would say to her social worker, "She may be doing well but you still haven't seen her true colors."
>
> Mary did not find a job for several months after she came into the program, and the one she finally secured proved to be only a temporary "Christmas rush" position as a clerk. When this ended unexpectedly for her she became extremely depressed by an arousal of her earlier feelings of rejection. However, Mary's relationship with her social worker had by this time become extremely important to her and provided her with considerable help in weathering this depression, so that in time she was able to secure a full-time office job. After several months on this job, she began talking of an independent living arrangement and eventually moved into a rooming house. She has since attended night school, and has apparently made a satisfactory community adjustment.

The girls are encouraged to participate in social and recreational activities in the community, although many of them need considerable support from the staff to do this. They are also encouraged to bring their friends into the residence. A number of parties and other recreational activities are held there for the girls and their friends of both sexes.

Several girls whose behavior while on parole warranted removal from their parole placement have also been taken into the residence for temporary care. Their placement there has permitted individual evaluation of the basis for their behavior and consideration of whether they should be returned to the training school, or, if not, what other plans should be made for them. Before the residence was established it was necessary to return girls who got into difficulties while on parole to the training school for such an evaluation. Several such girls after a temporary study period in the residence have been placed in new foster homes; others have received sufficient help through the program to be able to return to their own homes; and a few have been returned to the training school.

Since many of the girls in the training school are from New York City, some distance away from the training school, the use of the residence for this purpose has been very helpful. In addition, keeping the girls in the community has provided easier access to them for the girls' parents, foster parents, or aftercare social worker.

Pre-Release Guidance Centers

Pre-release guidance centers were opened by the Federal Bureau of Prisons in New York City and Chicago in September 1961, in Los Angeles in October of that year, and most recently in Detroit in January 1963. Each center accommodates a maximum of 25 juvenile and youthful offenders who remain for a period of 90 to 120 days prior to actual release into the community. By law, the only charges of the Federal Bureau of Prisons who can be placed in these centers are those who have been committed under the Federal Juvenile Delinquency Act or under the indeterminate provisions of the Youth Corrections Act. The policy is to place in them only those who have homes or release plans approved by the U.S. Probation Officers in the metropolitan areas where the centers are located.

The Chicago and New York centers are located in YMCA buildings, where wings of individual rooms with adjacent office space have been leased by the Bureau. The youth are encouraged to make use of the varied recreational opportunities afforded by the YMCA's.

The Los Angeles center is located in a building formerly part of a small college. Across the street from a large municipal park, the location is easily accessible by public transportation to all points in the Los Angeles area.

The Detroit center is located in a building formerly used by a voluntary agency as a home for dependent and neglected children. Because the Bureau of Prisons did not have a large number of youth from the Detroit area needing such placement, this center is jointly sponsored by the Bureau and the Michigan Department of Corrections, a cooperative sponsorship which also places young men in the center. Both groups are of the same age range—from 17 to 25.

Each of the Bureau's pre-release guidance centers has a trained, full-time staff consisting of a director, social caseworker-researcher, employment placement specialist, three counselors (except for the Detroit center, which has two), and secretarial staff. In the Detroit center the employment placement specialist is a staff member of the Michigan Department of Corrections.

The centers contain both high school students and employed workers, but the majority of the residents have full-time employment. Many of the latter, however, are enrolled in academic or vocational courses in evening schools.

All the centers encourage their residents to enroll in community programs, including those of religious organizations, recreational agencies, and the like. They also encourage visits of the young people with their families, on a progressive basis, in an effort to prevent the development of too strong a dependency on the center and its staff. Counseling, with individuals and with groups, has been made an important part of each center's program.

In the group counseling sessions, the group discusses adjustment problems—interpersonal relations, economic, disciplinary, or employment problems arising out of personal experiences of the young people at the center, in school, at work, or in the community at large. Both formal and informal meetings are held. One center uses films from a local public library to present social situations the young people may sometimes face—involving problems of drinking, dating, leisure time, and family life. In another center the caseworker introduces similar topics for discussion, being flexible enough, however, to allow individuals to bring up subjects bothering them.

Various community leaders have been brought in as guest speakers at these meetings—businessmen, employment counselors, teachers, armed forces recruitment personnel, union representatives, and law enforcement personnel. Following their formal remarks there is a discussion period during which the residents can bring up their special concerns about the subject. These have often dealt with the need for union membership in various types of jobs, requirements of job performance, appropriate appearance and manners when seeking employment, how to enlist in a branch of the armed forces, and vocational needs for employment advancement.

By August 1962, a total of 174 youths and juveniles had been placed in the 3 pre-release guidance centers. Of these, 20 youths have had to be returned to Federal institutions for further treatment and training or to State custody pending return to a Federal institution. After reviewing the histories of these 20, the Bureau's research staff came to the conclusion that they seem to be little different than the 154 who made good adjustments in this center.[6] Among the 20, the largest group failed during the first 2 months, but 3 were returned to the institution within a month. The chief difficulties among these 20 youth were in relating to persons of authority, in accepting the rules of the program, and in participating in the group sessions. Eight committed further delinquencies.

A Group Home for Boys

The Riverside Group Home for Boys, in Tacoma, Wash., was established in early 1962 by the Bureau of Juvenile Rehabilitation, Washington State Department of Institutions, for the purpose of caring for boys ready to leave the State's institutions and camps for delinquents for whom there were no placement plans. It is located in what was once the superintendent's residence of a Federal hospital for Indians which is now in the process of conversion to a State juvenile reception-diagnostic center for all delinquent youth committed to the State Department of Institutions.

The home accommodates a maximum of 15 boys. Its staff includes a supervisor, four counselors, a cook, and a part-time secretary. The boys remain in the home from a week to several months, depending on the length of time necessary to find them suitable independent community placements. Some boys attend regular public school classes, others take vocational training, and still others are employed full time during the day.

In operation, the Riverside Group Home is similar to the halfway houses already described. Plans are to continue to operate it as an independent program even after the new reception-diagnostic center opens, and the staff does not anticipate any difficulty in this direction. However, the question might be raised as to whether a residence situated in the grounds of an institution is "halfway" or "quarterway" between the institution and the community since the proximity to the institution may keep the residents from feeling really separated from it. This may not be a serious problem with the Riverside Group Home since the majority of the young people at the home will come there from the State's training schools and camps rather than from the reception-diagnostic center. However, when a halfway house is situated near an institution, it is especially important for it to have a noninstitutional appearance and for every effort to be made to involve its residents in community activities.

A halfway house in Tacoma, Wash., for boys on their way back to community life from an institution for delinquents.

Some Observations

The experiences of the few agencies which have established halfway houses for delinquent youth will undoubtedly prove valuable to others interested in strengthening their aftercare services for delinquents. From these have been derived the following observations:

- *The term "halfway house" is never part of the residence's name.*

Administrators and program planners, though commonly using the term "halfway house" in discussing their facilities, regard the term as unsuitable for public use for a number of reasons. For one, there is difficulty in getting the community to understand that young people are sufficiently healthy and safe to be at large in the community if they are living in something called a "halfway house," since the term seems to imply that the resident is only "halfway" ready for community life. Another reason, related to the first, is the fear that such a home will aggravate neighborhood resistance to being the location of a facility regarded as a possible threat to a favorable neighborhood image. For example, a residential center for emotionally disturbed children on the west coast had to sell a building bought for a halfway house because the neighborhood became aroused at the prospects of having such children in its midst. Thus, the trend has been to name these facilities group homes, pre-release guidance centers, transitional homes, and the like.

- *Community relationships are important.*

A successful halfway house program depends in part upon sympathetic community understanding. Efforts to gain such understanding begin long before the residence opens. For example, when the first halfway houses for discharged mental patients were being established, a period of at least 2 years was regarded as necessary for planning and community preparation. As such facilities become more widely accepted as essential to a total treatment program, the period of preparation can be shortened.

As soon as the decision as to location is made community interpretation should begin. This should focus on: the need for the program, the kind of young people who will be living in the facility, and the importance of community contacts to their successful adjustment to community life. It is especially important to obtain the cooperation of religious, recreational, and educational groups in extending a welcome to the young people, and including them in their programs. But it is also important for the people who live or work in the neighborhood to be knowledgeable and accepting of the program and its clientele. Otherwise the program may have to be terminated or moved to another neighborhood. This has happened more than once.

Some agencies have found it helpful to establish a citizens' committee which can work with the director to facilitate the community's acceptance of the halfway house. Such committees often also help the staff find employment for the residents and community activities in which they can engage. The committees can best facilitate acceptance of the programs if they are representative of the business, racial, religious, and professional groups of the community.

The Bureau of Prisons has found committees of this nature very effective in connection with its pre-release guidance centers in Chicago, Los Angeles, and New York. They consist of 8 to 10 persons in key positions to be helpful to the centers' staffs both in advising on program and in gaining community acceptance. For example, the Chicago committee consists of a member of the U.S. District Court; the chief probation officer of Cook County; the program chairman of the Chicago YMCA Council; a staff member of the School of Social Service Administration, University of Chicago; the executive director of the John Howard Association; the president of the coordinating council of the AFL–CIO; the former executive secretary of the Chicago Church Federation; and the captain of youth services of the Chicago police department.

- *The halfway house is but one type of facility needed in a diversified program for delinquent youth.*

The current interest in establishing halfway houses for delinquent youth is due in part to the growing interest in the development of diversified services and facilities for the care and treatment of delinquent children and youth. A diversified program meets the problem of overcrowding in institutions, permits the establishment of more homogenous treatment groupings of young delinquents, and assures them individualized care and help.[7] Besides the halfway house, other facilities in a truly diversified program for delinquents besides basic child welfare services, are detention facilities, diagnostic study centers, small residential treatment centers for seriously disturbed children, coeducational facilities for various age groups, foster homes, small group homes, and forestry camps.[8]

- *Various kinds of physical plants lend themselves to becoming halfway houses.*

Large private dwellings, series of urban row houses, and sections of apartments or agency buildings such as YMCA's are being used for this purpose.

The kind of plant needed depends on the number of young people to be served and the kinds of program activities to be included. Although no standard has been established regarding the advisable capacity for halfway houses, they generally are planned to accommodate groups of from 10 to 25 young people. Since the focus is on the improvement of social rather than vocational skills, areas for workshops and vocational programs are generally not necessary.

- *The clientele of halfway houses generally consists of young people who are ready to return to the community but who cannot return home, who are unable* *to accept foster home care, and who are not yet ready to live independently.*

Experience has shown the importance of careful consideration of the composition of the resident group by setting up criteria for selection. Such criteria will vary according to the program and focus of each house. A pertinent observation, however, is that "the closer the needs of the individual children . . . the easier it is to program for them individually and collectively. The wider the range of needs, the more difficult it is to use the group home constructively." [4]

An important criterion for all halfway house placements, however, is that the young people have sufficient inner controls to manage independently away from the house and its staff. Thus the young people placed in a halfway house set up for employed youth must have sufficient ability to function in an occupational role; and the young people who will be attending school while living in a halfway house must have the capacity to get along in a regular community school.

When an institution and a halfway house are operated by the same agency, the selection of the young people to be placed in the halfway house is generally made by an appropriate training school staff committee. On the other hand, when an institution and a halfway house are operated under different auspices, the halfway house generally has its own intake committee to decide upon the admission of individual youth referred to it from institutions, either directly or through their parent agency.

A Critical Need

One of the most serious gaps in programs for the rehabilitation of delinquent youth is in the aftercare of the delinquent in the critical period following his release from the institution. This gap was documented in 1962 in a report prepared for the Governors' Conference Committee on Juvenile Delinquency, based on information received from across the country from State agencies responsible for the care of delinquents.[9] According to this document, 35 States, Puerto Rico, and the Virgin Islands have reported a serious need for more aftercare services including halfway houses, group foster homes, short-term residential facilities, enlarged and more specialized parole services, and increased treatment rehabilitation and placement facilities.

The dearth of aftercare programs for delinquent youth has also been spotlighted recently by the National Conference of Superintendents of Training Schools and Reformatories, which has described such services as the weakest link in the entire chain of treatment of juvenile delinquents.[10]

Those agencies which are establishing halfway houses—unfortunately still only few and far between—are making an important contribution to the strengthening of that link.

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[1] Tunley, Roul: Kids, crime and chaos. Harper & Bros., New York. 1962.

[2] Maryland State Department of Public Welfare, and Health and Welfare Council of the Baltimore Area, Inc.: Report and proceedings, conference on halfway houses. Baltimore, Md. 1961.

[3] U.S. Department of Justice, Bureau of Prisons: Pre-release guidance center demonstration project. *Progress Report,* July–September 1962.

[4] Gula, Martin: Agency operated group homes. U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau. July 1960. (Mimeographed, 44 pp.)

[5] Wechsler, Henry: Transitional residences for former mental patients: a survey of halfway houses and related rehabilitation facilities. *Mental Hygiene,* January 1961.

[6] U.S. Department of Justice, Bureau of Prisons: Preliminary study of guidance center casualties. *Progress Report,* July–September 1962.

[7] Sheridan, William H.: Gaps in State programs for juvenile offenders. *Children,* November–December 1962.

[8] U.S. Department of Health, Education, and Welfare, Social Security Administration, Children's Bureau: Institutions serving delinquent children—guides and goals. CB Publication No. 360. Revised 1962.

[9] Council of State Governments; President's Committee on Juvenile Delinquency and Youth Crime; National Council on Crime and Delinquency: Juvenile delinquency: a report on State action and responsibilities. Prepared for the Governors' Conference Committee on Juvenile Delinquency. Council of State Governments, Chicago, Ill. 1962.

[10] National Conference of Superintendents of Training Schools and Reformatories: Institutional rehabilitation of delinquent youth. Delmar Publishers, Albany, N.Y. 1962.

> **The old conception of even-handed justice that each offender should receive exactly the same treatment is not the test of justice in the juvenile court. . . . In the juvenile courts children are all treated alike only when each is treated in accordance with his needs.**
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> *Grace Abbott, former chief of the Children's Bureau, in* The Child and the State, *Vol. II, 1938.*

An essay review . . .

INDEPENDENT ADOPTIONS—TEN YEARS LATER

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A NOTEWORTHY milestone in child welfare research is "Independent Adoptions,"* a recently issued report of a large scale, many-faceted followup study of 484 independent adoption placements made in Florida during the years 1944 through 1947. There were then few agency resources for placement in the State and consequently less likelihood that selective factors might distinguish agency from independent placements than in a locality in which more resources for agency placements were available. The sample of 484 adoptions constitutes a sizable proportion—about 30 percent—of all adoption petitions granted in the State in that period. Data were gathered during 1956 and 1957, approximately a decade later. This research was undertaken jointly by the Florida Department of Public Welfare, the Russell Sage Foundation, and the United States Children's Bureau.

The questions posed were:

1. How do the independent adoptions made under the Florida system about 10 years ago seem to be working out?

2. What, if any, factors in the adoptive home, in the adopted child and his background, in the way the adoption was arranged distinguish placements that work out well from those that have an unsatisfactory outcome?

3. Which, if any, of these factors are determinable at the time of the social investigation, and on what sorts of evidence can a determination be made?

A wide variety of research instruments was used. An adequate description of all of these instruments and a report of the methodological considerations involved in their use would require several times the space allotted to this essay review. Similarly, the few highlights from the findings which will be given cannot do justice to the many kinds of analyses of data which were made. The whole book deserves thorough study by every person seriously concerned with child welfare issues and problems, for the materials have implications broader than adoption.

All but about 10 percent of the adoptive mothers of children in the sample consented to an interview. Adoptive fathers were present for the whole or part of about 35 percent of the interviews but interviews with the fathers were not systematically sought. Since the vast majority of these children were placed in early infancy, at the time of the study most of them were preadolescents.

Homes were rated and classified as to some specific factors and also as to their "quality," these ratings being based on interview content. The interview covered information about the child's placement, socioeconomic data, health, and expressions of satisfaction or dissatisfaction with the adoption.

Adopted children in the sample were located in their schools and classrooms through the cooperation of the State Department of Public Instruction. In eliciting the cooperation of teachers, the study was not identified as research pertaining to adoption but rather as research in child development. From the school's cumulative records, results from intelligence tests and achievement tests were noted when these were available. In addition, certain tests were given to all the children in the classes of which the child was a member; others were given to the adopted child and four other children from his classroom, one of these four having been chosen as a control, matched with the adopted child on the bases of race, sex, and socioeconomic status.

These elaborate procedures protected the confidentiality of information concerning the identity of adopted children and safeguarded against the teachers' ratings being influenced by knowledge of the child's adopted status. However, an issue somewhat different from confidentiality may be involved here. This is a question rather of the *right of access to information.* Without the knowledge of adoptive parents, and whether or not parents had agreed to be interviewed, data from and about their children were secured.

Some Confusion

The division of this book into two parts creates a somewhat curious impression and some confusion as to the respective roles of the four co-authors. Part One, "The Followup Study," has 14 chapters, the last being called "In Conclusion." Part Two, called "Some Methodological Problems and Their Implications," has an introductory note and two chapters. Dr. Weinstein is its sole author.

One might think from the title of the second part that methodological problems had not been discussed in Part One. But such is not the case. A great deal of attention is paid there to the logic of the research design, to the methods of analyzing data, and to the difficulties in their interpretation. Part Two, however, raises new methodological questions, some of which challenge the use of the interview method and the reliability and validity of data thereby obtained. Some specific suggestions are made which would have modified the research design. Dr. Weinstein regrets that parents of the control group were not also interviewed and their ratings compared with the ratings of the adoptive parents.

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*Witmer, Helen L.; Herzog, Elizabeth; Weinstein, Eugene A.; Sullivan, Mary E.: Independent Adoptions: A Follow-up Study. Russell Sage Foundation, New York. 1963. 463 pp. $7.50.

One might also suppose from the title of Part Two that *only* methodological questions would be discussed but this is not the case either. Rather, new interpretations based on other forms of data analyses are presented, including a correlation matrix which intercorrelates 38 items of information yielding 703 correlations.

This reader wishes for one more, just *one* more "correlation," in the dictionary sense of "the act of bringing under relations of union or interaction" the two parts of the book. Were the Weinstein material integrated into the appropriate chapters of Part One, the methodological problems raised could be seen in better perspective, repetitious material could have been deleted, and the new analyses might have been more effective.

However, the division apparently reflects a divergence in philosophical approach among the authors. The statement is made in Part One:

> . . . The general climate of the home, the quality of the adoptive parents' marriage, the personality makeup of the mother, the quality of her and the father's relations with the adopted child are intangible and elusive. . . . Nevertheless, the relations between these elusive variables and the children's overall adjustment, assessed independently, were stronger than the relations between overall adjustment and any of the overt characteristics that can be determined with greater accuracy. . . . the overt, easily recognized characteristics of would-be adoptive parents and their homes cannot be relied on heavily for determining whether these people could offer a child a good opportunity to develop to his full potential.

A footnote refers to a "divergent view" presented in Part Two. This turns out to be:

> . . . focused detailed description rather than professional assumption may be a more effective approach to the problem of evaluation. Future studies of adoption outcome would be well advised to make adequate provision for obtaining reliable data on specific aspects of parental attitudes and child-rearing practices as well as more general 'psychodynamic' characterizations.

The response of future researchers to Dr. Weinstein's reproving advice must depend in part upon the purpose of the research. If a continued aim is to seek further clarification of the third question that this study posed for itself, which in brief was, *Are there factors predictive of outcome which are determinable at the time of the home investigation?* then the ultimate purpose is to use knowledge of such factors to prevent the placement of children in unsuitable homes. In that case, the "data on specific aspects of parental attitudes and child-rearing practices" would not yet have come to pass at the point at which the home study is made.

Predicting outcome, prior to placement, is necessarily dependent upon evaluation of qualities which are present in the persons and the situation when no child is there upon whom the effect of the manifestation of these qualities can be observed. These perhaps are those "less tangible and more elusive characteristics."

Independent vs. Agency Adoptions

A study such as this, involving large numbers of persons and situations, provides a sharp reminder that predictions in social work must be statements of probabilities, not guarantees of outcome. This study does not attempt to measure the success of independent placement as compared with those arranged by social agencies, yet undoubtedly this question will plague the thoughts of most readers.

Hopefully child welfare workers have grown beyond the need to try to convince themselves and a skeptical public that all independent adoptions will turn out badly and all agency placements will be successful. A more likely common sense prediction would be that: given the fact that the vast majority of babies are born with the potential for normal development, and the likelihood that most people wishing to adopt a child have the capacity for parenthood, the probabilities are that the majority of adoptions will work out reasonably well whether arranged independently or by agencies.

The scientific question then is, *Which system provides the better probabilities for successful outcomes?* If it be assumed that agency placements provide better probabilities, then the practical social policy question arises as to whether the difference in probabilities warrants the "infringement" upon the "rights" of the individual to adopt or justifies the expenditures of monies and resources of personnel.

Some Findings

What were some of the findings of this provocative piece of research? The vast majority (85 percent) of the adoptive parents found "unqualified satisfaction" with the adoption outcome. However, according to the home ratings 46 percent of the children were in homes rated "excellent to good," 25 percent were in homes rated "fairly good to questionable," and 29 percent were in homes rated as "poor."

There are no comparable ratings for the homes of the children in the control group, but this study assumes that adoption laws intend to insure, insofar as possible, that children placed in adoption will have *better* opportunities for development than those provided for children by the normal distribution curve of familial circumstances and parental capacities among parents rearing their own offspring.

It is hazardous to assay a summary comment about the proportions of children at the various adjustment levels, for a variety of combinations of tests and other data were used to derive overall ratings; and these different combinations yielded different results. A more meaningful summary comment is that the adopted children were found to be somewhat less well adjusted than the children in the control group, but that most of these differences disappeared when comparisons were drawn only between those children placed in adoption at less than 1 month of age and the children in the control group.

Good adjustment rates were associated with being in a home with a good rating: 84 percent of the children in homes rated "excellent" or "fair" had ratings of "well adjusted" or "fairly well adjusted" whereas only 16 percent of the children in such homes had the lower adjustment ratings. However, it seems that a good home is more strongly predictive of a good adjustment rating than a poor home is predictive of a poor adjustment rating, for while 54 percent of the children in the homes rated as "poor" did have the lower adjustment ratings, nonetheless 46 percent of these children attained ratings of "well adjusted" or "fairly well adjusted."

For certain categories of children—those placed after 18 months of age, those with adverse experiences prior to placement, and those with health problems—the quality of adjustment was more highly influenced by the quality of the home. Yet, unfortunately, these were the very children who were found to be "unusually likely to get into poor homes."

This suggests another policy issue concerning the deployment of our scarce professional services. If it be known that in certain kinds of situations, outcomes are likely to be predominantly satisfactory with or without professional intervention, whereas in other types of situations the probabilities for successful outcomes without professional services are less good, to which of these two sets of circumstances shall the short supply of professional help be directed? In connection with this it may be observed that at the present time our private agencies, which usually have better trained staff than most public agencies, are placing proportionately more young babies for adoption, and that public agencies are placing proportionately more older children.

Much valuable information has been set forth in this book. Moreover, the thorny problems encountered in the analyses and interpretation of data renew our appreciation for the fact that such words and phrases as "marital relationship," "parental capacity," "adjustment," and "potentials for development" are not unitary concepts. It is as important for social work practice as for research that the diverse elements encompassed within these multidimensional concepts be defined.

Continued research can further an understanding of the relative weights to be attached to these elements in accordance with their tested strength in balancing and counterbalancing other elements. Human situations are characterized by multiple causation and multiple effects. In social work practice there can be no escape from the necessity of understanding specific phenomena within the context of the whole. This study has not attempted to escape this necessity by the easy solution of the fragmentation of data.

Guides and Reports

TODAY'S CHILD AND FOSTER CARE. Child Welfare League of America, 44 East 23d Street, New York 10. April 1963. 62 pp. $1.25.

The five papers from the League's 1962 Eastern Regional Conference which comprise this booklet focus on meeting the individual needs of the child in foster care, services to the foster child's own parents, the development of a group home, recruitment and service to foster parents, and the essentials of a foster care program.

PROFESSIONAL EDUCATION FOR MATERNAL AND CHILD HEALTH. American Public Health Association, 1790 Broadway, New York 19. 1963. 157 pp. Single copies available on request from APHA.

The report of a conference on maternal and child health teaching in graduate schools of public health held in Minneapolis, Minn., March 1962, under the joint auspices of the Children's Bureau and the American Public Health Association's Committee on Relationships Between Schools of Public Health and Maternal and Child Health and Crippled Children's Services. (See CHILDREN, July–August 1962, pp. 166–167.)

BRIEF AND INTENSIVE CASEWORK WITH UNMARRIED MOTHERS. Child Welfare League of America, 44 East 23d Street, New York 10. April 1963. 41 pp. $1.

The first of the two papers included here, from the 1962 forum of the National Conference on Social Welfare, discusses casework with unmarried, first-time pregnant girls and women, with the emphasis on rehabilitation and prevention of recidivism. The second presents techniques for making the brief, initial contact with unmarried mothers a positive experience.

CUMULATIVE INDEX TO NURSING LITERATURE. Edited by Mildred Grandbois and others. 1962 January–June and July–December Supplements. Glendale Sanitarium and Hospital, P.O. Box 871, Glendale, Calif. 1962 and 1963. 102 pp.; 107 pp. For two semiannual parts, $10 to subscribers or $12.

These are the third and fourth semiannual cumulations covering literature pertinent to nurses. Each supplement contains about 3,500 references to articles which appeared in over 35 nursing, medical, and hospital journals during a 6-month period, indexing alphabetically by author, subject, and then cross-referenced, and also including a list of the journals indexed.

THE MARYLAND COMMISSION FOR CHILDREN AND YOUTH REPORT ON THE OUT-OF-SCHOOL, UNEMPLOYED YOUTH. Maryland Commission for Children and Youth, 301 W. Preston Street, Baltimore 1, Md. 1963. 32 pp. Single copies free on request from the Commission.

An illustrated report on the major aspects of the problem of unemployment among young people in Maryland, based on material gathered by the Commission in 3½ years of inquiry into the problem and on the findings of a statewide conference held under the Commission's auspices in 1962.

Some highlights of a national conference focused on . . .

FACTS AND MYTHS ABOUT RURAL YOUTH

KATHRYN CLOSE

FACTS AND MYTHS about rural youth, their culture, their needs, their prospects, and their desires came under intensive scrutiny for 3 days in mid-September at a National Conference on Problems of Rural Youth in a Changing Environment, held at Oklahoma State University, Stillwater, under the sponsorship of the National Committee for Children and Youth.

In its composition, origin, and focus, the conference itself supported one of its major outcomes—recognition of the interdependence of rural and urban life. Its participants were 500 persons who function from national, State, and grass-roots levels in the various fields which bring services or opportunities to young people—members of the professions concerned with education, health, welfare, recreation, job placement, and religion, and representatives of industry and labor—as well as a few rural youth themselves. Its focus was two-way: on young people growing up in areas of vanishing family farms, shutdown mines, or automated lumber camps; and on the country bred youth arriving in the city in search of a job. Its origin was a finding of the 1961 Conference on Unemployed Out-of-School Youth in Urban Areas (see CHILDREN, July–August 1961, pp. 151–152) that many of the out-of-school and out-of-work youth in our large cities come from rural communities where they have been ill-prepared for city life and work.

The facts of life confronting rural youth were available for all to see in 59 background papers on various aspects of rural economic trends, population characteristics, and educational, social, and health resources, prepared for the conference by experts on these subjects. Among those facts most frequently referred to from the platform and around the work-group tables were: only 1 out of 10 youths living on farms today can expect to make their careers in farming; training for nonfarm work is not available in many rural communities, and nonfarm jobs for the unskilled are rare; social, health, vocational guidance, and job placement services are inadequate in many rural communities, and nonexistent in some; half the 30 to 40 million persons in this country who live below the poverty line live in rural areas; educational attainments are lower among rural than among urban adults.

Along with these facts went descriptions of pockets of dire poverty and youth-abandoned communities across rural America—"In northern Minnesota the young people who are left don't even have jingling money." "In Clay County (Ky.) one-third of all the children are not in school."

Thus the American "myth" of the healthful simplicity of rural life was challenged. But many of the conference participants who bore testimony to the complex problems confronting rural youth today spoke feelingly of the values they had found in life on the land.

"There I learned responsibility in growing," said a 19-year-old participant in a youth panel in telling of her family's reluctant decision to give up their small dairy farm in the Ozarks.

Expressing faith in young people's ability to overcome adversity, the conference chairman, Winthrop Rockefeller, of Winrock Farms, Ark., in the opening address quoted from replies to a poll of youth's opinions, arranged for the conference, which seemed to indicate that young people had more faith in their parents, themselves, and the future than they were credited with by the "experts"—in this instance the conferees themselves, who had also participated in the poll. He maintained that young people are not frightened by the challenge of the rapid scientific advances which have taken place since World War II. Calling on the conferees to take a positive attitude toward youth, he suggested that community activities be tailored "not only to accommodate youth and their growth but to stimulate it on a realistic, sensitive, and dynamic basis even if it forces our adjustment to new mores."

Accent on Jobs

In its 5 general sessions (one a banquet, one a luncheon), 20 work groups, and 7 simultaneous "topical luncheons," the conferees looked at many aspects of rural life as they affect youth—employment, education and training, physical and mental health, problems of minorities, juvenile delinquency, community and family life—but almost invariably the discussion turned to opportunities and preparation for employment. There was apparently general agreement with Esther Peterson, Assistant

Secretary of Labor, when she said at the conference luncheon: "All the things we talk about come down to jobs, just plain jobs."

While acknowledging the benefits of technical change, Mrs. Peterson spoke of the "devastating effects" on those lacking the training or education to fit into the new economy. Among the 700,000 young people between 16 and 21 who are out of school and out of work, an "excessive proportion," she reported, are rural youth, many of whom have crowded into city slums. Likening the unemployed and marginally employed to an "underdeveloped country" within a highly prosperous nation, she called for support of various measures to help meet the problem—a vital program of continuous upgrading of skills, a minimum wage for farm workers, a youth conservation corps, a hometown youth corps, a national service corps.

"The full impact of the youth employment problem is yet to come," predicted Samuel V. Merrick, Special Assistant to the Secretary of Labor for Legislative Affairs, giving estimates that 5½ million new young workers are expected to enter the labor force between 1963 and 1965. He stressed the importance of education and technical training for farming and "agribusiness," the industries peripheral to farming, as well as for city employment, but he warned against too narrow a conception of training "in a society in which 8,000,000 people change jobs in a single year."

A sense of urgency for finding a way to head off or better prepare young city-bound escapees from a rural stalemate seemed to pervade the conference. In one workshop a participant told of an employment office in a midwestern city which sees as many as 2,000 young immigrants a week, "lost souls" who have arrived in the city without resources and without skills. "I wish people could see this thing—wish parents could see it—wish rural school boards could see it," he said.

This workshop sought ways of providing for a better flow of information between city employment services and rural communities so that the young job seekers would not arrive all at once, as they do in June at a time when few jobs are available. The participants seemed to agree that besides information about job trends it was important to get across two points to young rural people and their parents: (1) living in the city is different; (2) jobs today require proper preparation.

It was also pointed out that greater efforts might be made in urban communities by the churches, other youth-serving organizations, and governmental agencies to reach out to newly arrived rural youth to help them adjust to city life.

Some conferees, suggesting that there might not be enough jobs to go around even "if everybody gets trained," saw a need for measures to increase the total job supply. Others expressed great hopes in the technology's tendency to create new types of jobs—"50 percent of the boys and girls in school today by the time they reach retirement will be holding jobs that do not now exist"—in the trend among some industries to establish plants in rural areas "where the manpower is," and in the vast new highway systems that make the combination of city working and country living possible. A few questions were raised as to the effects of industrial decentralization on wages, and on family life in those rural areas where new industrial plants supply jobs chiefly to women. One workshop participant, saying he knew of many communities where "the women have jobs, but the men have nothing to do but pick up the kids after school," asked: "What kind of an image of their fathers will these kids have?"

Education, Training, Counseling

If the conferees believed in a panacea for the employment problems of rural youth, it was one with three heads—education, vocational training, and counseling. In rural areas, they had learned from the background papers and in many instances from firsthand experience, schools are often inferior both in program and teacher skills, especially where there has been resistance to the trend toward consolidation; school terms are sometimes shorter in order not to interfere with the harvests; parents' educational attainments and their educational aspirations for their children tend to be lower; lower proportions of rural than urban youth continue education beyond high school; secondary education programs are often geared only to college preparation, and vocational education and counseling, where they exist, to farming.

In one workshop the participants discussed the dilemma of providing schools large enough to offer the kind of enriching, remedial, and counseling programs that tend to keep children in school, yet not so far from the homes of those who live in isolated areas to discourage attendance. For example, what do you do in a State like Nebraska, where, although the average rural high school has an enrollment of only 75 pupils, some students still live as far as 35 miles away from their school? Devices mentioned as being used in some areas to improve programs in small schools were: mobile services—remedial reading, counseling, art and music instruction, family living courses—provided on a cooperative basis between school districts; closed circuit television programs; and motion picture libraries.

While consolidated schools, it seemed to be generally agreed, are in a better position to provide good teachers and programs, they face a problem of losing students from outlying areas who "do not have a sense of belonging." The blame was put on rigid school bus schedules which keep these students from participating in extracurricular activities. Many such students, it was reported, come from homes where education is not highly prized and so, without any feeling of ties to the school, they tend to drop out as soon as possible.

Understanding and skilled teaching were described repeatedly in the conference as basic to an effective education program. One young workshop participant bore witness to this by telling of how a high school teacher had helped him to "find himself." Now a freshman in college, he reported he plans to become a school counselor.

Rural youth's lack of access to differentiated educational programs, both at the high school and post-high school levels, received considerable attention. Among innovations suggested for solving problems of access and quality were the establishment of area technical schools, as in North Carolina, and junior colleges, as in Florida. After Florida opened its junior colleges, a workshop participant noted, the proportion of the State's high school graduates who went on to higher education rose from 7 to 41 percent.

Other Services

The interrelated problems of assuring both access and quality in service also received major attention in discussions of other needs in rural areas—informal educational programs, health services, programs for the physically and mentally handicapped, social services to prevent juvenile delinquency, court services.

For example, in a discussion of health services, it was pointed out that although maternal death rates had been found to be higher in small community hospitals than in large well-equipped and staffed hospitals, "every little community wants its own hospital." The suggestion was made that the accessibility to towns and cities provided by our modern highway system makes it feasible to concentrate on the provision of high quality service in fewer but larger hospitals.

State regional detention plans were suggested as one way of helping to solve the problem presented by the 100,000 children estimated to be held in jail annually in the United States, many of them in rural areas. However, it was also pointed out that other than formal detention arrangements could probably be made for most of these children if the communities took an interest in them.

Statewide family court systems were also suggested. Juvenile courts might just as well not exist, it was maintained, if, as is often true in rural counties, their judges have backgrounds in neither law nor social problems, and if they do not have social services available.

Getting the services that rural areas need, it was often stated, depends on community involvement and organization—a factor sadly lacking in many rural areas needing services most. "A community has to be organized to ask and get outside help," one participant commented, "and those that are so organized need the help the least."

Young people, as well as adults, have a responsibility for helping to improve their communities, some conferees suggested, a role which makes for good mental health but needs some stimulation through adult guided youth service programs. But it was pointed out that while 4-H clubs, Scout troops, Future Farmers of America, and other groups help many rural young people in this regard, in many isolated areas no such programs exist.

"In my community there aren't enough of us young people left to form a youth group," said a young workshop participant.

The proposed National Service Corps was suggested as a channel not only for bringing needed services to young people in distressed rural areas, but also for helping them to learn ways of serving their communities.

Equality of Opportunity

One "myth" attacked in one of the background papers was the concept of a youth subculture. Youth, said the authors, represent not one but many cultures, based on different bodies of experience and hence reactions. Thus the conference looked not just at rural youth in general but at the youth of the various minority groups in rural America—Negroes, Indians, the Spanish-speaking—and a group including all of these, migrant farm workers. All the disadvantages and problems that they found accruing to rural youth generally, they found in greater intensity among these groups.

Chief among the problems named as common to these groups was discrimination—in employment, in education, and in all types of community services. Lewis W. Jones, sociologist of Fisk University, a speaker at one of the topical luncheons, predicted that when the "legal and customary restrictions on the range and depths of Negro participation in American life" are finally lifted "the disabilities which have resulted from decades of neglect of Negro youth will become glaringly apparent."

The inconsistencies in a society which blames these disabilities on the persons suffering them instead of on the restrictions which created them were discussed in one workshop. There it was suggested that studies be made of current systems for the distribution of jobs, for the marketing of housing, and for the provision of services, in an effort to make "visible" the source of many of these conditions.

A vicious cycle facing all discriminated against minorities was described: The basic need of all is for jobs, but the jobs of today require education and the motivation for education is often lacking because job opportunities are so scarce. Reservation Indians often seem particularly lacking in motivation, it was reported, or at least in motivation for the kind of "success" which is important to white men. With Indians as well as with Spanish Americans, it was pointed out, a major problem is finding a way into the dominant culture and economy without losing the values of their own cultures. Said one participant: "If the Indian's culture requires him to share, why should we be shocked when he gives away everything he gets?"

What minority groups need now, more than one participant suggested, are opportunities that are *more* than equal to those of whites "to make up for hundreds of years of discrimination."

Children of migrant farm workers were described as suffering all the disadvantages of discrimination plus a special lack of stability in family, school, and community life.

How to get the unresponsive socially isolated segments of the rural youth population into youth activities and services came in for considerable discussion, with the frank acknowledgement that until recently most youth-serving agencies had not made much of an effort in this direction. The question which arose was: Could these programs be redesigned to fit the youth instead of expecting youth to fit the program? One participant, long associated with a large national youth-serving organization, went so far as to suggest that if shortages of staff and money forced a choice between the long-served middle class and the long-neglected disadvantaged groups, perhaps the service should go where the need is greatest. What happens, it was generally agreed, would depend on community attitudes and the quality of community leadership.

Brooks Hays, Special Assistant to the President of the United States, speaking at the conference banquet, called on the assemblage to make special efforts to "find ways to condition people to understand" the urgency of bringing equal opportunities in education, health, and all areas of life to all the youth of the land. "The impact of a disease germ upon an undernourished child is an act of violence," he said. "We must not rest until we have eliminated this and all other types of discrimination."

Stimulating Action

In one of the work groups a youthful participant asked: "But what can I do about all these problems?" She was told: "Take the facts back to your community."

The facts referred to were of two types—the alternatives facing youth in rural areas and the possible resources for improving them. Channels for getting the facts across and doing anything about them were admitted to be few in many rural areas, especially those so depleted of populations that "churches, schools, and lodge halls have been abandoned, leaving a void for those who remain." In many places, it was suggested, a "strategy of self-help" would have to begin with the development of indigenous leadership. State Committees on Children and Youth were named as an effective channel for awakening community awareness to the problems and stimulating community action.

The directions this action might take were spelled out in 250 recommendations prepared by the 20 work groups. As synthesized by Russel G. Mawby, assistant director of the University of Michigan's Cooperative Extension Service, for the final session of the conference, these had 10 major goals. The goals, and a few of the specifics mentioned by Mr. Mawby were:

1. *To increase awareness of the problems of rural youth:* the assumption of specific responsibilities by State delegates to the conference, who would report back to the National Committee for Children and Youth.

2. *To mobilize the rural community for action:* the evaluation and adjustment of programs to meet changing needs; coordination of voluntary and public efforts; innovations in administration to meet the particular needs of rural areas.

3. *To strengthen the schools:* improvement of vocational courses; flexibility and enrichment of curricula; the provision of post-high school training opportunities; special programs for the handicapped; teacher training and inservice efforts to improve the quality of rural school staff; organization for larger area administration.

4. *To initiate and expand related educational programs,* to be coordinated with school programs and to reach parents as well as youth.

5. *To improve programs in guidance and counseling,* to be extended to parents as well as youth, through the schools, but with the cooperation of local, State, and Federal resources.

6. *To expand opportunities for employment,* through measures to boost the general economy, to bring industries to rural areas, to extend minimum wage provisions to agricultural workers, and to encourage the maximum use of local labor in agriculture.

7. *To provide necessary community services:* innovations to reach people in thinly populated areas and also migrants; interprofessional planning for juvenile delinquency prevention; the establishment of minimum qualifications for judges and court services.

8. *To foster moral and spiritual values:* the participation of churches in community efforts to achieve a complete program for rural youth; new patterns of cooperation between the various denominations.

9. *To assist in adjustment to urban living:* the provision of occupational information to rural youth before they leave home; the formation of intergroup committees to serve as community youth commissions on employment and guidance; efforts to interest urban churches in rural in-migrants.

10. *To conduct appropriate research:* a study to determine the problems of rural youth in urban areas.

The Meaning

Two sharp paradoxes were revealed by this conference, according to Paul V. Miller, president of the University of West Virginia, who at the final session presented his analysis of what the conference had meant. These paradoxes he identified as: (1) the differences between belief and fact in regard to the quality of rural living; and (2) the depletion of institutions and services in rural communities in a time of great agricultural investment and advance. The predominant emphasis on the technical in our rural development, Dr. Miller said, has created an imbalance between our physical and human resources. Yet frustrated agrarian leaders are resistant to the innovations and educational improvements which might help to restore the balance, he maintained. "Too many hope that a new shirt factory in the community will do it. It won't."

"The chief value of what we may have learned here," said Dr. Miller, "is the interdependence of rural and urban areas in modern life. . . . the need to accept a less dogmatic concept of the community." He called for "a richer view of an enlarged geographical life," for a questioning of assumptions about ways of living and working, for a look at the possibility of consolidating political entities, for rearrangements of programs and personnel which deal with people.

The highways and communication systems of modern times, Dr. Miller predicted, will eventually eliminate the usefulness of the terms "rural" and "urban." Maintaining that the "by no means meagre" resources of this country should enable us to accommodate to this change, he pleaded:

"Let us help ourselves and others to live at the level of our time."

The response to Dr. Miller's plea, a standing ovation, indicated that there were many people in the audience who at least intended to try.

We press feverishly to conquer "outer space" while we leave unattended vast social areas of unconquered inner space. Too little thought and analysis have been directed toward assurance that individuals, particularly youth, are provided the opportunities and nourishment required for inner balance and security in a dynamically industrialized, technological age.

James R. Dumpson, New York City Commissioner of Welfare, at the 1961 meeting of the American Public Health Association.

AMONG THE STATES

The 1963 harvest of State legislative actions throughout the Nation included many measures affecting children. These were concerned with:

The Battered Child

Ten States created laws to protect the child who is physically abused by parent or other caretaker: *Colorado, Florida, Idaho, Indiana, Minnesota, Ohio, Oklahoma, Oregon, Pennsylvania.* and *Wyoming*. *California* already had such legislation, which was noted in developing the guide for State legislation requiring medical reporting of suspected child abuse, recently released by the Children's Bureau. (See CHILDREN, September–October 1963, page 202.) As in this guide most of the new legislation requires reporting by medical and related professional people of abuse cases to welfare, judicial, or law enforcement agencies; and contains clauses designed to protect those who do the reporting from legal liability. Some of the laws classify such abuse as a misdemeanor and spell out penalties.

Child Welfare Services

Idaho and *Oklahoma* enacted laws requiring licensing of child-care facilities including those for day care, and, in the case of *Idaho*, foster homes and maternity homes. This brings to 51 the number of States and other U.S. jurisdictions with licensing and certifying provisions for child care.

Colorado, abolishing a board of standards of child care, placed responsibility for licensing with the State Department of Public Welfare, and established an 11-member advisory committee representing the licensees, the State departments of health, education, and institutions, and the public at large. *Wyoming* provided general standards to be used by the State welfare department as a guide in establishing detailed standards for various types of child-bearing facilities; and *Iowa* extended its licensing requirements to include any home taking care of an unrelated child. The *Iowa* legislature also authorized the use of State child welfare funds to assist the counties in the support of children in foster care.

In *Pennsylvania* legislative changes assured public child welfare services for all children who need them whether or not they have resident status and provided for reimbursement of counties for costs of child care and treatment in foster care or in their own homes. It also provided for the State's operation, after 1968, of child welfare services in counties without adequate provision of such services, at these counties' expense. In *Maryland* the legislature set up an advisory council on child welfare, composed of representatives of State agencies, courts, voluntary agencies, and laymen; in *Missouri* foster-home care appropriations were increased more than 30 percent.

Inheritance rights of adopted children were clarified in *Idaho, New York, North Carolina*, and *Maryland*, as being the same as those of a natural child of the adoptive parents, once the order of adoption is made. *Maryland* revoked provisions allowing adopted children to inherit from the natural parents also.

In *Florida*, the State welfare department was authorized to place children for adoption and to charge specified fees. *Wyoming* clarified and tightened adoption procedures and joined the Interstate Compact on Placement of Children, of which *Maine* and *New York* are members as well. *Massachusetts* also joined the Compact. *Utah* provided for consent by minors to adoption of their children, and *North Carolina* and *Idaho*, for involuntary ending of parental rights in improper guardianship cases.

Illegitimacy and Nonsupport

The *Maryland* legislature requested the State Department of Public Welfare to develop a social service for women pregnant out of wedlock as well as for putative fathers. Also, on the basis of recommendations of the State Illegitimacy Commission, it added to the definition of "neglected child:" a child living in a home without a stable moral environment, including in the criteria for judging this environment whether the child's caretaker is, or has been in the preceding 12 months, pregnant out of wedlock. The new legislation provides for help to the family for 90 days after "neglect" is determined and the filing of a petition alleging neglect if the condition continues.

The *North Carolina* legislature eliminated the need, in cases of certain children born out of wedlock, for the natural mother's consent to adoption when she is judicially determined to be living out of wedlock.

A *Montana* law put the obligation to support an out-of-wedlock child on the father, and set up a legal framework to determine parentage.

Support laws were also passed in *California*, which spelled out the ways that the law enforcement and welfare agencies are to work together in getting fathers to support their children, and specified that fines levied for nonsupport are to be paid to the custodian of the child or, if the child is receiving public assistance, to the county welfare department; in *Minnesota* and *Missouri*, which gave authority to their State welfare commissioners to enlist the aid of other agencies in locating deserting mothers and fathers; in *North Carolina*, which defined willful desertion by the father as a felony; and in *Utah*, which passed a law patterned on the Uniform Reciprocal Enforcement of Support Act.

Public Assistance

Laws broadening State programs of aid to families with dependent children were passed in a number of States.

California, Kansas, Kentucky, Michigan, and *Washington* extended coverage to include children of unemployed parents, bringing to 18 the number of States with authority for such assistance.

Eight States passed laws allowing AFDC payments to be made to children in foster care: *Georgia, Kansas, Michigan, Minnesota, Missouri, New York, Texas* and *Vermont*, making a total of 30 States that allow such payments.

Alaska and *Minnesota* permitted children in the AFDC program to save their earnings for an approved purpose.

Minnesota was also among the eight States to provide the legislative basis to pay grants to a person other than the head of the household, if necessary to protect the children. Others were *Illinois, Louisiana, Oklahoma, Kansas, New York, North Carolina*, and *Texas*.

Nebraska eliminated the requirement that students between 16 and 18 years old must maintain satisfactory grades in all classes to be eligible for payments.

Texas, which was the only State with a maximum age of 14 for eligibility to AFDC, raised the age limit to 16.

Some States set up new restrictions on public assistance programs:

Illinois set ceilings for the first time on payments—$80 a month for one child and relative and $20 a month each for the next 7 children and $10 a month for the 9th and 10th children and none for those beyond; but allowed additional allowance for rent in certain cases. *Missouri* required a physical or mental examination of persons whose incapacity was the basis for an application for AFDC, by a physician appointed by the State's welfare agency. *Ohio* made it mandatory for assistance recipients to accept work on public projects or to take vocational training.

Juvenile Delinquency

Some approaches to preventing delinquent behavior were taken by the legislatures in: *California*, through authorization of a 2-year program that calls for $346,000 to help school districts keep youths with serious problems in school by providing them with home counseling and cultural enrichment in 9 pilot projects, as well as through a 1-year program to train youths between 16 and 22 years of age in forest and conservation practices; *Indiana*, with the setting up of a commission to study the problem of school dropouts; and *Wisconsin*, through two new youth camps to be built and operated with the State's outdoor resource development funds of about $188,000.

In *North Carolina*, juvenile court judges were given the power to commit delinquent children to the custody of the county welfare agency for placement in suitable homes; and county public welfare directors were designated as chief probation officers of juvenile courts which have no probation staffs. In *Kansas*, two or more counties were authorized to join in providing a detention home or juvenile farm. In *Missouri*, representation by public defenders was extended to minors appearing in juvenile courts, under certain conditions; and provision was made for the return of a child sent to the Division of Mental Diseases by the juvenile court or Board of Training Schools, but found not needing care for mental diseases.

Nebraska authorized juvenile court judges to appoint referees; deleted the right to request a jury trial on the part of a delinquent child charged with a crime; limited the pre-adjudication period of custody and spelled out conditions under which a child can be taken into custody without a warrant or court order; and narrowed the definition of a delinquent child so as to omit children who have not violated a State law or village ordinance.

Colorado limited the appointment of investigators by juvenile courts to courts in counties with more than 200,000 people. In *Idaho*, hearings of youthful offenders were made closed to the public and public inspection of probate records was forbidden, at the court's discretion. In *Montana*, arson and assault in the second degree were included among crimes for which a child over 16 years may be prosecuted.

The *Hawaii* legislature prohibited "glue sniffing" and passed protective provisions for persons giving case information to medical study groups.

Delaware, North Carolina, and *West Virginia* joined the Interstate Compact on Juveniles.

Other laws related to young people's behavior were passed in *Florida*, where juvenile courts were authorized to transfer traffic violators to adult courts; and in *Illinois*, where a curfew law prohibited youngsters under 18 from being on the streets after midnight on weekends and 11 o'clock on other nights.

Structure and Operations

Among major structural changes brought about by 1963 legislation were:

- In *Georgia*, a new Division of Children and Youth within the Department of Family and Children Services, formerly the State Department of Public Welfare, bringing together State juvenile delinquency services with child welfare services for dependent and neglected children. A policy-making board was established for the new division. Licensing responsibilities were clarified and extended to include day care and maternity homes.
- In *Idaho*, the Department of Public Assistance was made responsible for providing protective services for neglected children; child welfare services for children in their own homes; and shelter care for neglected and abused children brought before the courts. The Department was authorized to accept legal custody of children committed to it by the probate court, to place children for adoption, and to consent to adoption. An interdepartmental committee on children and youth was established to coordinate administrative action in the fields of child health, education, and welfare.
- In *Illinois*, a new Department of Children and Family Services to provide social services to children and their families when unavailable through other public and private agencies and to operate schools and institutions for physically handicapped and dependent children and provide certain rehabilitative services for adults.
- In *Kentucky*, a new Division of Social Services within the State Department of Economic Security to provide more social services and counseling to public aid recipients, including children.
- In *Montana*, a new Department of Institutions which binds together 10 of the State's institutions.

Miscellaneous

Programs for mentally retarded children were affected by legislation, in:

- *Minnesota*, for grants-in-aid to local communities and nonprofit groups for the setting up of daytime activities for about 350 mentally retarded children out of $155,000 in funds for 2 years.
- *Colorado*, for $60,000 in appropriations to cover the first year of a comprehensive study, including pilot demonstrations, of a community program for the mentally retarded and the seriously handicapped.
- *Wyoming*, for special classrooms to be set up in the public school system for educable and trainable mentally retarded children.

Kansas modified its abortion law to exempt cases based on danger to health as well as life, and repealed a law prohibiting the sale or distribution of information, drugs, or devices to prevent pregnancy. The legislature also made health examinations compulsory for all school personnel every 3 years.

In *Colorado*, a law was passed prohibiting discrimination based on race, creed, color, sex, national origin, or ancestry in apprenticeship programs, on-the-job training programs, or vocational schools or by joint apprenticeship committees.

—Eleonora Chatty

BOOK NOTES

THE LIMB-DEFICIENT CHILD. The Child Amputee Prosthetics Project, Department of Pediatrics, School of Medicine, University of California, Los Angeles. Edited by Berton Blakeslee. Photographs by Mary Louise Histon. University of California Press, Berkeley 4. 1963. 391 pp. $8.50.

This volume describes the interdisciplinary methods and treatment techniques in use by the Child Amputee Prosthetics Project at the University of California School of Medicine at Los Angeles. Contributors include the project's medical director, medical social workers, research prosthetists, research physical and occupational therapists, and others.

The book's nine chapters deal successively with the role and functions of the medical director, orthopedic considerations, psychosocial problems, preprosthetic evaluations and therapy, child prosthesis design and fitting, the training period—including stump hygiene and prosthesis care, and upper and lower extremity training.

Photographs, drawings, graphs, tables, and charts are included.

READINGS IN ADOPTION. Edited by I. Evelyn Smith. Philosophical Library, New York. 1963. 532 pp. $7.50.

With the statement that "each child is worth our thought and care for himself alone," the editor of this anthology, a former Children's Bureau consultant on foster care, introduces the 40 articles she has brought together in it from the literature on adoption.

The book is organized into five parts. The first four, composed of chapters written by social workers long experienced in services to children, present general concepts as well as the philosophy underlying adoptions and discuss adoption services in relation to natural parents, the child, and the adoptive parents. The final section presenting contributions of persons in professions other than social work, including pediatricians, psychiatrists, lawyers, and psychologists, includes, among others, chapters on the application of psychoanalytic concepts to agency practice, problems in developing research on adoption, the legal profession's responsibility in adoption, and criteria for predictability. In the final chapter, "A Forward Look," the editor names some goals for agencies and communities, underscoring the development of "broad citizen interest and participation in planning and supporting adoption and related programs."

The volume is presented as a groundwork for policy makers and planners as well as for adoption workers.

INFANTS IN INSTITUTIONS: a comparison of their development with family-reared infants during the first year of life. Sally Provence, M.D., and Rose C. Lipton, M.D. Preface by Milton J. E. Senn, M.D. International Universities Press, New York. 1963. 191 pp. $5.

Through the use of infant tests and precise clinical observations, the authors of this book compared a group of 75 infants reared in an institution with a group of infants reared in foster homes. Attention was focused on the complete "life space" of the child in the institutional environment, including staff behavior, the physical environment, the presence or absence of stimuli in the child's experience. The authors documented the qualitative nature of many stimuli, including the tactile, visual, auditory, affectional, social exploratory, and constancy of mother substitute. They found deficits in all these areas, especially in the personal interactions called "mothering."

The developmental progress and learning experience of the institutionalized infants are described in detail to show the specific effects at various age levels of the institutional environment. Among reported effects are retardation in social interaction, language development, reaction to toys, and self-discovery.

The authors also followed the institutionalized children after their placement in foster homes at the ages of 9 months to 5 years. The children were seen from one to six times and many of them showed signs of improvement. Here the effects of the early institutionalized life experiences are carefully traced, though in some instances the theorizing is speculative. Thus, there are suggestions in what areas the early damage can be reversed, and in what areas there appear to be indications of irreversability of the effects of early deprivation. In all instances, there is apparent a qualitative effect on the child's development as a result of the early experiences of institutionalization.

MOVING INTO MANHOOD. W. W. Bauer, M.D. Foreword by Morris Fishbein. Doubleday & Co., New York. 1963. 107 pp. $2.95.

Revolving around the theme that sex makes a boy into a man but "getting to be a man" also means growing up emotionally, socially, and intellectually, this book directed to teenage boys discusses such subjects as: physiology of sex and reproduction, relations with parents, especially with fathers, boy and girl relationships, where to go for help with problems, the use of tobacco, alcohol, and drugs, and choosing a marriage partner.

STUDIES IN ADOLESCENCE. Edited by Robert E. Grinder. The Macmillan Co., New York. 1963. 524 pp. $4.50.

This book of readings in adolescent psychology brings together, in a series of papers, previously published elsewhere, theoretical essays and research reports on the adolescent in today's American society. Among the specialties represented by the authors are: psychology, anthropology, sociology, and education.

The major portion of the readings deal with the various forces of socialization as they affect the adolescent, while a smaller section consists of papers on physical and intellectual growth during adolescence. Topics accorded considerable emphasis include the following: the effect of social class upon youth behavior, particularly in the school setting; motivation, academic achievement, and creativity.

HERE AND THERE

School Dropouts

As a federally sponsored back-to-school campaign begun in early summer drew to a close in September, preliminary results showed that more than 10,000 potential dropouts in 20 cities had been persuaded to continue their education. This was reported by the Office of Education, U.S. Department of Health, Education, and Welfare, on the basis of evidence from 20 of the 63 communities for which a total of $250,000 had been made available in August from Presidential emergency funds for counseling youth identified as school dropouts. Allocations ranging from $300 to $20,000 financed the efforts of some 600 counselors.

The report showed that school counselors interviewed more than 23,000 young people—43 workers in the District of Columbia identified 1,833 dropouts, had conferences with 1,267 of them, and persuaded 800 of them to return to school.

This effort made inroads into the expected total of 400,000 dropouts predicted for this school term by the Office of Education on the basis of past experience.

Another segment of the Federal campaign, sponsored by DHEW's Welfare Administration, was directed toward encouraging junior- and high-school-age youth in families receiving aid to families with dependent children (AFDC) or child welfare services to go back to school this fall. Acting on a proposal from this agency in July, State welfare agencies in 33 States and the District of Columbia, in cooperation with public school authorities, embarked on special anti-dropout drives, according to reports received by the Bureau of Family Services in early August. These drives included such features as allowing children on the AFDC rolls to keep some of their earnings for school expenses without reduction in their family's assistance check; paying for glasses, hearing aids, and other items; arranging for vocational training or a combined work-school program; paying for day care for preschool children if teenage children would otherwise have to stay home to care for them. For these efforts, the Bureau of Family Services was able to pay up to 75 percent of the cost under dependency prevention provisions of the 1962 public welfare amendments that took effect July 1.

A model back-to-school demonstration project—sent in outline to all States in late July by the Bureau of Family Services—for which Federal funds could finance 100 percent of the cost was adopted by four States by mid-September. All but 12 States had responded in some way to the Bureau's urging to encourage AFDC children to remain in school. Welfare staffs visited children aged 13 through 17 years of age in AFDC families, worked out plans to assure their return to school, and later evaluated the success of the effort.

Visits were made by public welfare staff to a high proportion of the junior and senior high school children in AFDC families, as well as to families receiving child welfare services. Some States mailed notices or letters to all families known to public welfare agencies who have children.

These special efforts on behalf of the potential dropout were the outgrowth of a conference in Washington, D.C., in mid-July, at which educators, school board members, and public welfare officials from 28 major cities discussed ways of encouraging the thousands of youths expected to join the ranks of dropouts to go back to school this fall. The conference, called by the Office of Education, was held in response to an appeal to act on the dropout problem by President Kennedy at the White House on June 19.

Efforts of the U.S. Department of Labor to encourage young people to stay in or go back to school have for some time included informational-educational efforts on a broad front: the dissemination of booklets and other audiovisual material, a film ("When I'm Old Enough, Goodbye"); cooperative agreements with advertising, sports, and other organizations for mass publicity on the importance of schooling for youth; and an emphasis on the importance of schooling in its program of vocational guidance and counseling carried out through the State employment services, in cooperation with high school counselors. All these efforts were stepped up during last summer's special campaign.

Educational Television

In early September the first five grants, amounting to $858,152, were made under the Educational Television Facilities Act of 1962, legislation designed to foster broadened and better television facilities for the schools. (See CHILDREN, July–August 1962, page 164.) Expected to cost a total of about $1,290,000, the projects receiving these funds will provide educational service to areas with over a million people. The grants were: $299,619 to the Chicago Educational Television Association for a new station on channel 20; $129,143 to the Educational Television Association of Hampton Roads, Va., for studio equipment on channel 15 at Norfolk; $99,865 to the Utah State University of Agriculture and Applied Science for a new station on channel 12 at Logan; and to the South Carolina Educational Television Commission $270,303 for a new station on channel 29 at Greenville, and $59,222 for a new station on channel 7 at Charleston.

The Mentally Retarded

Some 400 persons from the fields of health, welfare, education, and vocational rehabilitation in every State, the Virgin Islands, and Puerto Rico met in Warrenton, Va., for 3 days in mid-September for a White House Conference on Mental Retardation, called by Dr. Stafford Warren, special assistant to the President for mental retardation, at the request of the President.

The purpose of the Conference was to stimulate coordinated program planning among official agencies at all levels and between these and private groups.

At the opening session, addresses by Sargent Shriver, executive director of the Joseph P. Kennedy, Jr. Foundation, Leonard Mayo, chairman of the President's Panel on Mental Retardation, and of officials of the various units of the U.S. Department of Health, Education, and Welfare described the scope and implication of the problem of mental retardation, predicted to involve more than 6 million people by 1970, and outlined the Department's program for tackling it.

Dividing into six work groups, the participants then focused on mental retardation from the perspective of their agencies' particular functions as well as of professional teamwork. Some principal threads of discussion were: the need for mechanisms related to the conditional use of matching funds; statewide enforceable standards; the availability of State consultative services; and experience with interagency councils for coordination.

Speakers at the final plenary session, which was exclusively on prevention, stressed the importance to the Nation of the quality of reproduction, which, it was maintained, "is poor and getting poorer;" the inadequacy of facilities and resources for ante partum care in some States; the value of broadening research avenues to causes of and methods of preventing and treating retardation; and the need for reducing cultural deprivation among underprivileged families, in the light of research that attributes a large segment of mental retardation to behavioral factors after birth.

Research

A resource for research on enzymes, the mysterious catalysts in body cell chemical reactions, is to begin operation this winter at Tufts University School of Medicine in Boston under a contract made with the Public Health Service in mid-July. The new center will isolate and purify, on a large scale, enzymes and naturally related substances not so far available in the quantities or in the state of purity required for biomedical research. These are to be made available for basic medical research.

The center's program will be administered by the National Institutes of Health with the advice of a committee of eight scientists, including two from outside the area. An allocation of $645,000 in Federal funds has been made for its first 18 months of operation.

Training

A 3-year demonstration project to develop inservice training for public assistance workers who are employed in the program of aid to families with dependent children but are unable to obtain professional education was launched this fall in the State of Washington. Federal funds approved for the first year of its operation totaled $244,600 for the project's new State training center in Seattle. These comprised $59,000 in demonstration project funds made available by the 1962 public welfare amendments and $185,500 under another 1962 provision allowing 75-percent payment by the Federal Government of certain inservice training costs incurred by the State.

In its first year the project calls for 10 months of intensive training—classroom lectures and discussion programs alternating with closely supervised work with AFDC families—for a selected group of 18 public welfare workers with at least 1 year's experience on the job.

Unmarried Mothers

A demonstration project in which 30 unmarried pregnant teenage girls continue their education as a group in a special school and receive counseling, casework, health, and psychological services was launched this fall within the public school system of the District of Columbia. Envisioned as a springboard for a continuing program geared to the educational, health, and general welfare needs of unmarried mothers, the 3-year project is a coordinated effort of the District's health, welfare, and education agencies, financed by a grant from the Children's Bureau.

The project employs a multidisciplinary team of three teachers, a clinical psychologist, two psychiatric social workers, and a research consultant. The girls, expected to number about 60 in daily attendance, are referred to the project from private and public health and welfare sources and from schools. After acceptance into the program, they will follow the regular school calendar, including summer sessions. A full program comprises, in addition to four academic subjects, a course in personal and family living, interviews with psychologists and social workers, and appointments with appropriate health services for prenatal and post partum care, and hospital delivery.

The project also includes plans to evaluate such factors as the students' growth in emotional stability and in responsibility for acceptable social behavior; acceptance by the girls and their families of group affiliation with other pregnant schoolgirls; and the program's effectiveness in fostering good health of the girls and babies. Also, there will be an attempt to delineate those things which determine whether the program is accepted or whether it is rejected.

Integration

Racial discrimination has been prohibited in any of the programs of county or private welfare agencies licensed by the California State Department of Social Welfare under an order issued by the State's welfare director, J. M. Wedemeyer, toward the end of last summer.

The order requires that:

- Admission and care practices be maintained on a nondiscriminatory basis in day nurseries, child-placing and adoption agencies, maternity homes, and special boarding and day-care homes licensed by the Department.
- Written declarations be made by all State licensed facilities that they operate on a integrated basis and such declarations be made available to the public.
- Administrative processes of all counties be reviewed to root out discriminatory practices in relief and welfare programs and special training be developed for workers dealing with minority groups.
- The State welfare department train its administrators and supervisors in minority group relations and develop far-reaching antidiscriminatory programs affecting State services, local public agencies using State funds, and private agencies licensed by the State.

Delinquency Prevention

A grant of $1 million has been awarded under the Juvenile Delinquency and Youth Offenses Control Act to Cleveland's Community Action for Youth for the first year of a 3-year demonstration project to prevent and control delinquency in the city's multiproblem Hough neighborhood. Another $1 million is being contributed by local groups in funds and services.

The project includes more than 50 new programs, some of which involve: occupational counseling in a center that gives remedial education for dropouts, employment orientation, and skill training; a preschool family nursery; prekindergarten readiness activities; communication skills improvement in elementary schools; and classes for junior and senior high school students with special disciplinary problems.

The funds are also expected to allow the start of a new district public welfare office in Hough to give priority to child neglect cases; work programs for boys on juvenile court probation; a program for unmarried pregnant girls, including prenatal medical service; and a "youth incentive program" to give recognition to young people's achievements in school sports and community service.

For Youth

A 1-year federally supported project in which 1,000 semi-literate, unskilled youths, 16 through 21, are given classroom instruction in the "three R's" as well as job training is under way in Chicago, under the sponsorship of several local and State agencies. These include three voluntary agencies, the Young Men's Christian Association of Metropolitan Chicago, the Chicago Boys Club, the Chicago Youth Centers, and the following governmental agencies: the Cook County Department of Public Aid; the Illinois State Employment Service; the Illinois State Department of Vocational Education; and the Chicago Commission on Youth Welfare. Funds for the project, called Job Opportunities Through Better Skills (JOBS), come from grants authorized under the Manpower Development and Training Act of 1962: $541,000 from the U.S. Department of Labor for trainee selection, testing, counseling, job development, placement, and follow-up costs; and $485,000 from the U.S. Department of Health, Education, and Welfare for training costs. In addition, the U.S. Department of Labor will pay the cost of training allowances for youths in the program.

Youths selected to participate by the local agencies are out of work and out of school, and for the most part have achievement levels of no more than the sixth grade. They receive lessons in basic education—including reading skills and practice and number skills—for about 6 weeks. This is followed by skill training tailored to fit individual aptitudes and needs, in automotive and mechanical skills, clerical skills, and food service. About 600 of the young people will receive on-the-job training, learning—while doing—to be stock clerks, waiters, office machine assemblers, landscape gardeners, and workers in a variety of other occupations.

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A $3 million program to help open the doors of skilled employment to some 20,000 unemployed youths in New York City was begun in early July with a Federal contract of $2 million under the Manpower Development and Training Act and $1 million from the city.

Youths to be trained under this program, called Job Orientation in the Neighborhoods (or JOIN for short), will be drawn from the 16–21 years age group which represents an estimated 26 percent of the city's total of 300,000 unemployed, most coming from the generally deprived Negro and Puerto Rican communities.

The program developed out of the city's Neighborhood Resources Development Program. It will be directed by the Mayor's Council on Expanded Employment Opportunities and Training.

Among program plans are vocational guidance, testing, counseling, job training, job tryouts, and placement. Training programs under MDTA are being developed for youths served at the Neighborhood counseling centers. Also expected are agreements with employers, employer associations, and unions for job training and placement, and job surveys.

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Ten returning Peace Corps volunteers began teaching this fall in Cardozo High School in Washington, D.C., as part of a pilot demonstration project called Washington Action for Youth (WAY). The project, which focuses on one of the city's high delinquency areas, was created by the Juvenile Delinquency Planning Board of the United Planning Organization, a body incorporated last December to launch a major demonstration project to prevent juvenile delinquency and provide opportunities for youth in the National Capital area. Launched with a grant of $225,000 from the President's Committee on Juvenile Delinquency and Youth Crime, it began operation of a multifaceted program last spring.

In the use of returning Peace Corps volunteers, an attempt is being made to demonstrate that there are parallel conditions in teaching a Peace Corps situation and in deprived areas of this country. The former volunteers teach part time and follow a specially devised curriculum of education and subject matter courses at Howard University. They are paid $4,500 each for the school year.

One of WAY's activities thus far has been a summer employment program which by the middle of July had found jobs for about 1,300 youths between 16 and 18; and, coordinated with this (and with the "Future for Jimmy" project of the Washington Urban League), a program in which roving leaders supplied by the D.C. Recreation Department counsel young people, help them find part-time or summer jobs, and encourage them to return to school to prepare for full-time employment after graduation. Another of WAY's planned activities is a pre-cadet training program, sponsored in cooperation with the District school system and the Police Department as a recruiting source for police cadets.

Just getting under way is a WAY youth center for counseling, testing, and placement of out-of-school unemployed youth, launched this September and operated in cooperation with the U.S. Employment Service and the District school system.

Federal funds supporting these WAY projects come from grants made under the Juvenile Delinquency and Youth Offenses Control Act and under the Manpower Development and Training Act.

Vital Statistics

Tenth in 1961, the United States apparently has slipped back to 11th place among countries ranked on lowness of their infant mortality rates, according to provisional figures for 1962 or the most recent year available. The provisional U.S. rate for 1962 is 25.3 per 1,000 live births, the same as for 1961. (See CHILDREN, September–October 1962, p. 201.) Ireland, which was in 13th place in 1961, according to the provisional 1962 figures moved into 10th place with a rate of 24.2.

Since 1950, Finland, Japan, Ireland, and the Federal Republic of Germany have cut their infant death rates about in half. The Netherlands, Norway, Denmark, and Switzerland, with rates already well below the United States, have made reductions of about one-third in their infant mortality rates. In the United States since 1950 the reduction in infant mortality has been about 13 percent.

The countries compared are known to use World Health Organization definitions of live birth and of infant death, have relatively complete reporting, and populations over 300,000 in 1960, or a recent census.

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With 4,167,362 babies born in the United States in 1962, fewer than in any year since 1955, the 1962 rate of 22.4 live births per 1,000 population was the lowest since 1945. This represented a drop of 3.9 percent from the 1961 birth rate. Also lower was the 1962 fertility rate—calculated as live births per 1,000 females aged 15–44 years. This rate was 112.1 in 1962, compared with 117.2 in 1961. In the last 5 years the birth rate and fertility rate have dropped 11.5 percent and 8.6 percent, respectively.

Federal Legislation

In October, the 88th Congress enacted the 1963 "Maternal and Child Health and Mental Retardation Planning Amendments" to the Social Security Act. These:

- Increased authorizations for grants to the States for maternal and child health and crippled children's services—from the $25 million each—by steps of $5 million a year, to $50 million each for fiscal 1970 and subsequent years.
- Authorized a new 5-year program of grants to State and local health departments for maternity and infant care projects, directed primarily to women in "high-risk groups" who would otherwise be unable to pay for needed medical care. The objective is to help reduce the incidence of mental retardation caused by complications associated with childbearing. Amounts authorized for this program were $5 million for the fiscal year 1964, $15 million for fiscal 1965, and $30 million for each of the next 3 fiscal years. The Federal grant may not exceed 75 percent of the cost of a project.
- Authorized grants or contracts for those research projects in maternal and child health or crippled children's services that show promise of substantially contributing to the advancement of these programs. Funds for this purpose were authorized up to $8 million for any fiscal year.
- Added a new title (Title XVII) to the Social Security Act authorizing one-time grants to the States for up to 75 percent of the cost of planning comprehensive action to combat mental retardation. Appropriations of $2.2 million were authorized to be available through the fiscal year ending June 30, 1965.

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In late September, the 88th Congress appropriated $86,344,000 for activities of the Children's Bureau during fiscal 1964. This amount included $3,401,000 for salaries and expenses—about $458,000 over the total for this item in 1963, including supplemental appropriations. The amounts included for grants for maternal and child welfare, totaling $82,943,000, were: $25 million for crippled children's services; $25 million for maternal and child health services; $29 million for child welfare services—of which $4 million is earmarked for the development of day-care services in the States (see CHILDREN, September–October 1962, page 199); and $3,943,000 for child welfare research, training, or demonstration grants.

READERS' EXCHANGE

GRANT AND WARREN: *A rare opportunity*

Generally, throughout the country we have been going through the motions of juvenile court procedures, probation, institutionalization, and parole without clearly developed treatment plans. Court commitments to institutions have soared without evidence that training schools offer more effective treatment in a given case than would improved probation services in the community.

While crash delinquency prevention programs search for quick remedies, evaluation of our basic correctional programs is overlooked. It is not improbable that mass production caseloads, overcrowded detention homes, juvenile halls, and training schools contribute substantially to delinquency when little more than lipservice is given to treatment.

The Community Treatment Project described by Marguerite Q. Grant and Martin Warren in the July–August 1963 issue of CHIDREN ["Alternates to Institutionalization"], with its interdisciplinary approach and use of appropriate community resources, has a rare opportunity to define casework methods more clearly. If it succeeds in this, it could make two important contributions by providing: (1) material for more effective training of probation and parole agents: (2) a practical basis for caseload standards unlike anything now available. The key questions are whether the project allows sufficient time for the results to be valid, and whether the report will be presented in a form usable for these purposes.

Three years is hardly long enough to undertake treatment and evaluate its effectiveness. The project was half over at the time the article was written, yet the average length of time subjects were carried in the community program was only 10 months. At least 3 years should be allowed for observing results after the intensive community treatment is concluded.

Interim reports are often misleading because the facts are not all in. It is hoped that in the final report, the three broad maturity levels will be carefully spelled out together with the dangers common to all classification systems—misinterpretation of symptoms, overlap, and tendency to rely on inflexible formula. The report of the project conceivably could have immense value for training child welfare workers and probation officers. If early detection and treatment had been built into child welfare and probation services, the boy who had had nine foster home placements might never have had to be committed to the Youth Authority.

As the authors recognize, there are courts which use their probation departments as a treatment tool and commit less than 5 percent of their delinquents to institutions. There are also institutions, with the same type of delinquents as those admitted to the project, which claim to have an 85-percent success record. Since the project has already returned about 15 percent of its experimental subjects to the institutions, it can hardly be expected to top the 85-percent claim.

The answer we are searching for is likely not to *exclude* the institution but more clearly to define its proper use and the need for a variety of smaller specialized facilities used in conjunction with redefined treatment in the community.

Sherwood Norman
Director of Detention Services, National Council on Crime and Delinquency, New York

HOSLEY: *For the culturally deprived*

In her article, "Culturally Deprived Children in Day-Care Programs" [CHILDREN, September–October 1963], Eleanor Hosley provides an example of an area in which services to the culturally deprived can be especially effective. Describing the type of individual care and understanding needed to provide an enriching experience for each child, she also makes clear the importance of the child's experiences in a group.

Most of our teachers in day-care programs come from middle-class backgrounds. Thus they may need help in understanding the child whose background is different. Culturally deprived children may respond differently than middle-class children to people and situations because of different life experiences. Often social workers can help teachers not only to understand the family's background but also to verbalize their own feelings about these children. For example, the teacher may need help accepting the child whose eating, cleanliness, and behavior differ from the majority of children in the group and from her own standards.

I would like to stress the importance of a strong social service component in a day-care program in assuring that the experiences the child has are to be constructive ones, related to the child's total life situation. The social worker becomes central to an effective program since it is through her work with the parents that what happens to the child during the day will be related to his experiences in the family unit.

The day-care agency having policies developed primarily to serve the middle-class family may find that a re-evaluation of these policies is necessary, if the culturally deprived child is to be served. Are the fees too high for families who do not understand the need for an educational program? Can a rigid policy of excluding sick children be interpreted to those parents who have little concern about health standards? Can a 6 o'clock closing time be rigidly enforced? The agency needs to "start" where the client is.

It is hoped that the recent provision of Federal funds to support day-care services will result in more services being made available under public auspices to the culturally deprived groups. Such services should include not only day-care centers for the 3- to 6-year age group but also appropriate services for the very young child and the school agers who also need care and protection. Those who plan services should give careful consideration to the possibility of breaking depriving family patterns through the development of strong family day-home programs to serve children from such backgrounds.

Malcolm Host
Executive Director, Day Care Association, Houston, Tex.

KAHN: *Counting the positives*

I read with much interest Alfred Kahn's article, "The Citizen's Role in Social Welfare Policy" [CHILDREN, September–October 1963], and find myself in accord with several points that he makes. It is certainly high time that we deal with social problems in terms of the social change which is now taking place. It is high time that we strike a better balance of policy discussion relative to traditional rehabilitation services and preventive programs. It is high time, also, that better planning operations take place in order to underpin sound policy formulation.

There is, however, one aspect of Dr. Kahn's article that bothers me. It is the omission of any positive discussion of the *structures* achieved over the years for citizen participation in social policy formulation in the field of child welfare. Dr. Kahn refers to the need for periodically dealing with basic issues and changing problems but makes no reference to the White House Conferences that have been held periodically for over a half a century. In my opinion they represent a monumental achievement in joint lay and professional planning and policy formulation.

The child welfare services plan in practically every State in the Union is an instrumentality of the highest order for utilizing lay and professional persons in planning and policy formulation. Many States, in the formulation of foster care licensing standards, have developed committee arrangements to ensure citizen participation. Certainly licensing standards not only represent "public policy," *per se*, but also constitute a truly preventive service. Witness also, the development of planning and policy groups for day care—at various levels of government—which provide a wholesome structure for a dialogue between lay and professional individuals on a current community problem that has come as a result of "accelerated social change."

In citing the above examples, which are only a few of many in the field of child welfare, I am not implying that I believe we have achieved a utopian arrangement for citizen participation in social policy formulation. I do believe, however, that they represent a significantly positive achievement which should be noted in any analysis of the topic.

Norris E. Class
Professor, School of Social Work, University of Southern California, Los Angeles

For Parents

POINTS ON PREGNANCY. Thomas C. Points, M.D. Esteem Associates, Stillwater, Okla. 1963. 200 pp. $5.

A guide for expectant mothers.

A PARENT'S GUIDE TO CHILD PSYCHOTHERAPY. Howard M. Halpern. A. S. Barnes & Co., 11 East 36th Street, New York 16. 1963. 178 pp. $3.95.

PARENTS' GUIDE TO CHILDREN'S VISION. James R. Gregg. Public Affairs Committee, Inc., 22 East 38th Street, New York 16. Public Affairs Pamphlet No. 339. 1963. 20 pp. 25 cents. Quantity rates available.

SOME U.S. GOVERNMENT PUBLICATIONS FOR PROFESSIONAL WORKERS

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COUNSELING AND EMPLOYMENT SERVICE FOR YOUTH: Supplement I to "Counseling and Employment Service for Special Worker Groups." November 1962. Department of Labor, Bureau of Employment Security. 1963. 84 pp. 40 cents.

Designed to be used as a supplement to the discussions in "Counseling and Employment Service for Special Worker Groups," this publication describes the procedures applied in providing vocational counseling and employment and placement services for high school graduates and school dropouts, and also for the college graduate. An appendix contains a variety of screening forms used to determine the work or educational plans of students.

CHILDREN, PROBLEMS, AND SERVICES IN CHILD WELFARE PROGRAMS. Helen R. Jeter. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 403. 1963. 291 pp. $1.

A report of a 1961 nationwide study made by the Children's Bureau in cooperation with the Child Welfare League of America, focusing on the kinds of problems children served by public and voluntary child welfare agencies had and the services these agencies provided them. (See "Here and There," CHILDREN, March-April 1963, p. 82.)

FAMILIES OF MONGOLOID CHILDREN. Elizabeth R. Kramm. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 401. 1963. 56 pp. 25 cents.

Based on home interviews with the families of 50 Mongoloid children who were living at home, this report presents findings—illustrated with direct quotations from the parents—on the parents' reactions to having a Mongoloid child and the emotional impact of learning that the child is handicapped, their fears for the child's future, and their views of the child's effect on the parents' and family activities and his relationship with siblings and other children in the community.

Findings of the study indicate that the attitudes of professional persons who first oriented the parents to the medical diagnosis had a direct bearing on the parents' adjustment to the child's condition. A section on the implications of the study for services to families of retarded children is included.

SERVICES FOR THE CHILD WHO IS HARD OF HEARING: a guide for the development of programs. Don A. Harrington. Department of Health, Education, and Welfare, Welfare Administration, Children's Bureau. CB Publication No. 402. 1963. 38 pp. 20 cents.

A completely rewritten revision of a 1950 publication, this booklet discusses concepts and principles pertinent to the establishment and further development of State and local hearing conservation programs. Its major emphases are on: prevention; early identification and multidisciplinary evaluation and diagnosis; effective medical, surgical, and audiological services; and improvement and extension of community health education.

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